

**CMS-0050-P-107**

**Submitter :** Mr. Benjamin Loy  
**Organization :** National Health Systems, Inc.  
**Category :** Health Care Industry

**Date:** 01/20/2006

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attached

CMS-0050-P-107-Attach-1.PDF



**NHS Comments on the Proposed Standards for  
Electronic Health Care Claims Attachments  
(CMS-0050-P)**

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**Written Comments Submitted by:**  
Benjamin E. (Ben) Loy, R.Ph.  
Sr. Vice President, Industry Relations  
National Health Systems, Inc.

**To:**  
U. S. Department of  
Health and Human Services  
Centers for Medicare and Medicaid

**Extended Public Comment Period:**  
Through January 23, 2006

The National Health Systems, Inc. (NHS) companies appreciate the opportunity to submit comments to the U. S. Department of Health and Human Services Centers for Medicare and Medicaid on the proposed regulation to provide standards for health care claims attachments.

NHS is composed of a several software development companies including the wholly own subsidiary PDX, Inc., a retail pharmacy software provider, that was established by Ken Hill in 1985 in Granbury, Texas and which was preceded by the still viable pc1, Inc. a software application provider primarily to independent pharmacies. The PDX pharmacy system is the most widely distributed single-source retail pharmacy application in North America and is used for prescription processing by independents, small to moderate sized chains and large national pharmacy chains. PDX and its affiliated companies provide pharmacy technology to a customer base of approximately 1,000 independent pharmacies and some 60 chains for a total of more than 10,000 pharmacies. These pharmacies serve more than 60,000,000 customers each year and fill approximately 720,000,000 prescriptions annually. PDX has installations in all 50 states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. PDX has earned a position as a leader in pharmacy technology innovation including currently available central-fill and centralized database technology. PDX is working to provide our customers and their clients with secure broadband access to both an electronic medical record and to a personal electronic medical record. PDX has participated in the standards development process for over two decades and promotes such standards as a value to our company, our customers, the retail pharmacy industry and to the country itself.

**NHS written comments to the U. S. Department of Health and Human Services (HHS) on the proposed Standards for Electronic Health Care Claims Attachments.**

The Standards Development Organizations (SDO) that participated in developing the proposed claims attachment standard and code sets were X12N and HL7. These are both highly recognized and well respected organizations that represent dozens if not hundreds of different businesses and provide standards that are widely used by many members of the health care industry. These organizations provide health care claims processing standards that primarily utilize Electronic Data Interchange (EDI) that is processed in batch mode and which is not generally considered to be time critical. The HIPAA named SDO that was not a direct contributor to the proposed claims attachment standard was the National Council for Prescription Drug Programs (NCPDP) an organization that develops standards used primarily by the 60,000 retail pharmacies and pharmacy benefits managers. The membership of NCPDP has moved over the past three decades from paper based claims, to electronic batch billing processes and finally to a true on-line real-time claims processing environment that is the envy of the world. The claims process developed by the NCPDP membership has greatly contributed to the efficiency and cost effectiveness of the U.S. retail pharmacy industry.

As a technology developer NHS understands that retail pharmacy represents a unique entity within the health care arena with regard to the techniques used in claims processing. As such, we know that methodologies that work for other segments of the industry do not necessarily work for retail pharmacy. Although not specifically mentioned as being covered by the proposed standard, retail pharmacy is also not specifically exempted. The inclusion of information concerning medications in section 162.1905(c)(3) as qualifying a covered entity as having to comply with this subpart may be interpreted to include retail pharmacy, which we do not believe was intended. Such a requirement would impose an excessive and truly unfair requirement on retail pharmacy as EDI batch processes are not easily integrated with on-line real-time claims billing. If attachments do become needed for retail pharmacy claims then the SDO that supports this industry, NCPDP, should be given the opportunity to determine the requirements and the most appropriate means of addressing such needs.

However, if the intent was to include retail pharmacy under this rule, then HHS must conduct a thorough analysis, studying how these attachments would impact the pharmacy claims billing processes and the impediments that such use could raise. Implementing this rule on retail pharmacy without such analysis could seriously impact the retail pharmacy claims billing process and possibly result in the inability to provide pharmaceutical care (prescriptions) to healthcare beneficiaries. Pharmacies have been significantly impacted by the HIPAA Privacy Rule, HIPAA Transactions and Code Sets Rule, HIPAA Security Rule and Medicare Part D in recent years and are looking at the implementation of the HIPAA National Provider Identifier (NPI) within the next 18 months. All of these programs have imposed significant costs on the retail pharmacy providers.

## **Conclusion**

We strongly recommend that retail pharmacy be exempted from the proposed Standards for Electronic Health Care Claims Attachments. Retail pharmacy's use of an on-line real-time claims adjudication process would be negatively impacted by the required use of the recommended EDI batch electronic health care claims attachment standards. We do not believe HHS intended this and request it be clearly stated that retail pharmacy is exempted from this rule.

**CMS-0050-P-108**

**Submitter :** Mr. Brent Barnhart  
**Organization :** Kaiser Permanente  
**Category :** Health Plan or Association

**Date:** 01/20/2006

**Issue Areas/Comments**

**GENERAL**

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See Attachment

CMS-0050-P-108-Attach-1.PDF



January 20, 2006

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-0050-P  
P.O. Box 8014  
Baltimore, MD 21244-8014

Re: File Code CMS-0050-P: NPRM for Standards for Electronic  
Health Care Claims Attachments

Kaiser Permanente appreciates the opportunity to comment on the Notice of Proposed Rulemaking (NPRM) for Administrative Simplification under the Health Insurance Portability and Accountability Act of 1996 (HIPAA): Standards for Electronic Health Care Claims Attachments, published by the Department of Health and Human Services (HHS) in the *Federal Register* on September 23, 2005 (70 Fed Reg. 55990).

Kaiser Permanente is an integrated health care program operating in 9 states and the District of Columbia. The program includes a health plan, a hospital system and several Permanente Medical Groups that serve the plan's 8.5 million members. The program thus approaches these proposed electronic claims attachments from the perspective of both a payor that adjudicates claims, and a provider of health care services that submits claims for payment. Kaiser Permanente has invested heavily in, and is strongly committed to, the development and implementation of electronic health care information systems. We therefore support Administrative Simplification efforts that promise to replace costly and time-consuming paper claims systems with far more efficient electronic systems. At the same time, however, we wish to voice concerns and propose what we intend to be constructive amendments, where we believe the rules as stated in the NPRM pose unintended problems for payors and providers.

1) Implementation:

The proposed rules adopt specific approaches for which there has been very little piloting that demonstrate their effectiveness -- rules that will be locked into place once implemented. The proposed rules require compliance 60 days plus 24 months following publication of the final rule. That is far more rapid than the 60 days plus 24 months with the added 12 month contingency period, e.g., permitted to implement the EDI rules. Experience from the New York (Empire) pilot underscores the need for additional testing. There has been, for example, no testing of the computer decision variant explained in the ASC X12N and HL7 Claim Attachment Implementing Guides which would better support electronic auto adjudication.

Furthermore, some of the boundaries of LOINC subparts are not well defined. While LOINC Laboratory standards are well defined and reasonably sound, the LOINC Clinical standards are

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not yet fully accepted nor adequately mapped. Appropriate work is necessary to ensure that there are defined boundaries and relationships across federal clinical code standards. For example, a sanctioned and maintained mapping between SNOMED and LOINC is needed as a prerequisite to the inclusion of Clinical LOINC codes in the final rule. It is far too expensive and inefficient to leave such mapping between standards to individual organizations. We recommend, therefore, that implementation be delayed pending further testing of 277 and 275 claims attachments – preferably in different sites throughout the country. There should be further testing of auto adjudication, and further testing of boundaries and relationships.

## 2) Claims attachment responses:

The rules require payors to prepare to comply with a provider request to use electronic claims attachments – to undergo significant investment in costs and administration – with no assurance that providers will request to use electronic claims attachments, or what format will be used in a response. We note, furthermore, that the proposed rule gives providers unlimited authority to send imaged documents in claims attachments. Administrative simplification will not result if payors are expected to receive imaged versions for any and all claims attachments responses. It is entirely possible that the costs of receiving and storing large volumes of imaged documents will be equal to or exceed the costs of paper claims attachments.

We recommend that the final rules permit covered entities to develop trading partner agreements that address many of the technical formatting requirements. Trading partners could agree, e.g., to specify whether a response should contain text-only information, image-only information, or text or imaged format, at the option of the provider.

## 3) Single attachment limit:

A health care payor may make only one 277 request for a given claim. This poses a problem where in adjudicating a complex claim the payor learns of the need for additional information from a provider's first claims attachment response (275). We note that state prompt pay laws, and the ERISA Claims Rules already delimit the time that payors may take in adjudicating a claim. There is no incentive for a payor to demand additional claims attachments ad infinitum as a means of deferring payment.

We also note that since a payor may continue under the rules to request non-electronic documentation without limitation, delimiting 277 electronic claims requests to one per claim is likely to undermine a payor's willingness to rely on electronic claims attachments.

To the extent that limits on the number of attachment requests are intended to curtail network traffic, system server capacity, processing load factors and other such technical considerations, we maintain that the limits are not germane to the current technical environment of healthcare systems. The pervasive use of internet-based technologies in healthcare, the transmission and archiving of DICOM image files, the near realtime processing of membership and other administrative transactions, and the current volumes of standards-based messages for systems interfaces, all demonstrate that no such artificial limits should be imposed in the rules for

technical reasons.

We recommend that the proposed rule be amended to eliminate the restriction on the number of attachment requests that can be solicited by a payor, provided the payor complies with established federal or state statutory timeframes for claims adjudication.

4) Post adjudication requests:

Though the preamble states that a payor may in certain circumstances request additional information after a claim has been adjudicated, e.g., to review for potential fraud or abuse, the proposed regulation is silent, neither expressly addressing nor permitting post adjudication requests. Existing federal Medicaid regulations require payors to request attachments in certain circumstances. We recommend, therefore, that the rule expressly address appropriate circumstances, such as potential fraud or abuse, or for Medicaid purposes, where a payor may request additional information from a provider following adjudication.

5) CDA Release:

We support adoption of CDA Release 2 in place of CDA Release 1, provided CDA release 2 is adequately piloted. In fact the rules should use the most recent CDA release tested at time of implementation. However, if a decision is made to adopt CDA release 2, the Secretary should give sufficient notice of the change to permit vendors to plan and budget process, testing and deployment.

6) Standards Maintenance:

Following adoption of a final rule and implementation, the rules should permit further adoption of new attachment types and modifications of attachment types through the DSMO process, culminating in NCVHS recommendations to the Secretary, rather than the lengthy NPRM rule adoption process. As clinical practice and technology evolves, new versions of standards should be adopted that are backwards compatible, and that permit continued use of two versions of standards at the same time. The process should also include provisions for sunsetting older versions of the standards after an appropriate transition period. The DSMO should be authorized to adopt new attachments and new versions that are developed, balloted and published by the appropriate SDOs, currently ASC X12 and HL7. The overall process should include provisions for outreach and comments in the appropriate SDO processes, then notification in the Federal Register and adequate time for implementation after appropriate SDO publication.

7) Overlap between data elements:

We concur with the six initial claims attachment types incorporated in the proposed rules. There is, however, overlap between data elements in the attachment information and the existing 837 electronic claim transaction. The impact of overlapping data needs to be addressed by the standards organization, and clarified in the rules.

8) Systems reliability:

The rules should provide guidance on application of the final rule in the case of systems reliability issues or problems. Guidance should include provisions to ensure accuracy and completeness of data transmitted in attachments, provisions to mitigate claims-related workflows based on obsolete, erroneous or incomplete electronic attachments data, and provisions for the use of human-readable documents that are not perfect (lossless) copies of the original (scanned) document.

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**CMS-0050-P-109**

**Submitter :** Mr. Martin Jensen  
**Organization :** Healthcare IT Transition Group  
**Category :** Health Care Industry

**Date:** 01/20/2006

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-0050-P-109-Attach-1.DOC

Comment re: File Code CMS-0050-P  
45 CFR Part 162

HIPAA Administrative Simplification: Standards for Electronic Health Care Claims  
Attachments; Proposed Rule

## **SOLICITED VS. UNSOLICITED ATTACHMENTS**

*We are proposing that health care providers may submit an unsolicited electronic attachment only when a health plan has given them specific advance instructions pertaining to that type of claim or service. (FR Vol. 70 No. 184 p. 55999)*

This and other elements in the section related to unsolicited attachments are neither feasible nor fair. This conclusion is supported by the results of the WEDI/HL7/X12/AFEHCT National Healthcare Claims Attachment Survey<sup>1</sup>, which I helped to coordinate.

- ❑ The notion of “specific advance instructions” calls into question the definition of an “unsolicited” claims attachment.
- ❑ According to the survey results, payers have no uniform method of telling providers when to send attachments. When asked how such information is communicated, 63% said they “Almost Always or Frequently” sent the information by mail, 21% by Phone Call, 7% by E-Mail, 16% by Fax, 8% by EDI and 8% by DDE/On-Line (p. 43).
- ❑ No standard method exists for codifying such payer requirements.
- ❑ Most significantly, the absence of any such instructions from a particular payer is tantamount to permission to defy the Rule. The NPRM does not mandate payers to disclose such instructions, nor does it grant providers a remedy should they fail to disclose. All a payer must do to avoid accepting unsolicited electronic claims attachments is to deny disclosure of their terms or to define terms that are inconsistent with their adjudication practices. In either case, manual submission will remain preferable to providers.

### **Providers Can Disclose, but Choose Not To**

The concern here seems to be in regard to unwanted attachments. But our survey results show that payers’ methods are inconsistent in communicating this information to providers.

*Question 17: When the health plan receives unwanted or unneeded documentation or attachments, how is the provider notified to quit sending them? (p. 45)*

<sup>1</sup> This report is available online: <http://www.wedi.org/snip/public/articles/ClaimsAttachSurveyFinalRpt.doc>

## Healthcare IT Transition Group

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### Health Plan Response: Preventing Unwanted Attachments

	Publish Attachment Requirements	Send Policy Message to All Providers	Send Ad Hoc Message to Individual Providers	Publish Rules in Provider Contracts	Refrain from Telling Providers about Rules or Requests
Almost Always	18	12	3	7	4
Frequently	13	17	9	3	3
Sometimes	22	18	25	17	5
Rarely	3	9	12	8	4
Never	7	6	10	15	27

In practice, providers learn which attachments to send by tracking the suspensions and denials of claims that are sent *without* attachments. If payers want to reduce the number of attachments they receive, they can do so by voluntarily disclosing their requirements. In fact, if paper attachments are indeed so much more costly than their electronic counterparts, then payers should already be doing so now. But most are not. There is no need to incorporate any further protection into the rule if they are unwilling to protect themselves using the means already at hand.

### Willing Payers Will be Harmed

Payers who wish to comply with both the spirit and the letter of the law would also be at a disadvantage. If the law allows their competitors to opt out of implementing unsolicited attachments, they stand to lose significant ROI for their own systems. Why? If providers are constrained in submitting electronic unsolicited attachments (as they are not with paper attachments), they may be reluctant to adopt the technology altogether. For the willing payer, there may not be enough volume to provide optimal payback.

### Unsolicited Attachments are Critical to the Success of the Rule

How important are unsolicited attachments? Much more than the authors of the NPRM seem to think (see COSTS AND BENEFITS section).

*The volume of unsolicited attachments accompanying original health care claims today is relatively small. (FR Vol. 70 No. 184 p. 56017)*

In fact, unsolicited attachments may be more prevalent than those stemming from a specific request. From the provider survey, we found over 56% said they Almost Always or Frequently sent the attachment with the original claim, while a significantly lower number (47%) said they Almost Always or Frequently waited for a payer to request one. What's more, the difference is all in the absolutes: 33.0% said they Almost Always send unsolicited, while only 24% said they Almost Always waited (p. 31). To a third of our providers, "attachment" is synonymous with "unsolicited attachment."

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Provider results supported this case: an equal number of respondents (42%) indicated that providers almost always or frequently sent attachments with the original claim as did so after a specific request (p. 42).

Certainly a factor in the continued need for unsolicited attachments can be found in a third statistic from that same question: 30% of payer respondents indicated that attachments were "almost always or frequently" sent after denial of the original claim. When it comes to attachments, this phenomenon of "request by denial" provides a strong incentive for providers to submit an "unsolicited" request the next time. In fact, one would expect such denials to be a more potent form of communicating the payers' wishes than any "specific advance instructions."

Damming a clear-flowing stream of unsolicited attachments means that fewer providers will bother to look at electronic attachments at all. Fewer providers demanding the service means lower vendor interest, and thus lower rates of adoption and far less savings from administrative simplification. Our survey results showed that Customer Demand was the most important factor driving vendor adoption, a full seventeen percentage points over Customer Regulatory Mandates (p. 16).

### **No New Minimum Necessary Concerns**

There seems to be a gap in the logic concerning Minimum Necessary standards:

*If health care providers were permitted to submit unsolicited electronic attachments with any claim without prior arrangement with the health plan, there would be a number of issues, including compliance with the Privacy Rule's minimum necessary standards, and identifying the new business and technical procedures health plans would need to develop to review, evaluate, store, return, or destroy the unsolicited documents. (FR Vol. 70 No. 184 p. 55999)*

First, the requirements of Minimum Necessity apply to all protected health information, not just that disclosed electronically. Changing the mode of transmission from paper to electronic media does not relieve the provider to evaluate for necessity, nor does it create requirements where none existed. And even if this were the case, the existing protections in the Privacy Rule would surely be preferable to creating a new "mini Privacy Rule" in this regulatory text.

### **Voluntary Efforts Can Make Unsolicited Attachments Work**

Preventing unnecessary attachments is of benefit to both parties. However, no standard exists to communicate this information, and the traditional reluctance of payers to disclose their requirements must be overcome.

The draft rule, however, provides only a disincentive for this discussion to take place. Please remove the passages that restrict the use of unsolicited attachments beyond those

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privacy protections already in place. This is  
necessary for the full value of electronic claims attachments to be fulfilled.

Sincerely,

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**CMS-0050-P-110**

**Submitter :**

**Organization :** Utah Health Information Network

**Date:** 01/21/2006

**Category :** Health Plan or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-0050-P-110-Attach-1.RTF

**Utah Health Information Network  
Claims Attachment NPRM Comments**

Issue Identifier	Page Number	-Section# -Column# -Paragraph#	Text	Comment to NPRM
Overview of Clinical Document Architecture	55995	C2c3p2	However, if Release 2.0 is approved by HL7..	Based on small provider resources, which include cost and personnel, we recommend that all AIS documents use CDA 2.0.
Overview of Key Information for Electronic Health Care Claims Attachments	55996	C4c1p2	Thus, version 4050 of the X12N 277 ``request`` and version 4050 of the X12N 275 ``response`` are proposed to carry the attachment related questions and the related answers or responses.	We support using the X12N 277/275 version 4050 to carry attachment related questions and the related answers or responses, if the X12N 277/275 version 5010 implementation guides is not available prior to the final rule (claims attachments) being published.
Electronic Claims Attachment Types	55996	B5c3p2	The health care provider will send both....	It appears that the attachments pilot did not pilot the ""text"" option of the Human Decision Variant. Was this option used? If not piloted we recommend that one advocating this method be completed and further information/instruction should be supplied.
Format Option (Human vs. Computer Variants) for electronic claims attachments	55997	B6c1p4	Even with this variant...	Please supply style sheets for both payer and provider or let us know where they can be found.
Electronic Health Care Claims Attachment business Use	55998	D c3p3	Attachments may be requested or submitted...	We would recommend that the scope of the attachments should include; appeals, corrections and any payment adjustments not just first time adjudication.

**Utah Health Information Network  
Claims Attachment NPRM Comments**

Issue Identifier	Page Number	-Section# -Column# -Paragraph#	Text	Comment to NPRM
Electronic Health Care Claims Attachment business Use	55998	D c3p3	Attachments may be requested or submitted..	Why keep the attachments tied to the claim - all administrative transactions should be allowed to use the attachment rule to standardize the health care data. All administrative transactions be included in the rule.
Combined Use of two Different Standards through Standard Development Organization (SDO) Collaboration	55998	B7c2p2	However, because these two standards..	As the versions progress the two standards should remain compatible. If one standard is changed then it must be tested with the standard that is not changing to ensure compatibility.
Electronic Health Care Claims Attachment business Use	55999 56000 56001 56002 56003 56004 56005 56006 56007 56008 56009 56010 56011 56012 56013 56014 56015 56016 56017 56018 56019 56020 56021 56022	D2c2p1 D2c2p2 D2c2p3 D2c2p4 D2c2p5 D2c2p6 D2c2p7 D2c2p8 D2c2p9 D2c2p10 D2c2p11 D2c2p12 D2c2p13 D2c2p14 D2c2p15 D2c2p16 D2c2p17 D2c2p18 D2c2p19 D2c2p20 D2c2p21 D2c2p22 D2c2p23 D2c2p24	We are proposing that health care providers	We agree that providers should not be allowed to send unsolicited supplemental information with out the advance instructions from a payer. The group feels that there are already rules in place that speak to timely payment by payers. Addressing the issue of allowing the payer only 1 request may force the payer to do the following:  The Payer requests every possible record that may be applicable. This is burdensome to the provider. This would negate the value of using the electronic attachments. In the paper world if additional information is requested there are no limits on requests.

**Utah Health Information Network  
Claims Attachment NPRM Comments**

Issue Identifier	Page Number	-Section# -Column# -Paragraph#	Text	Comment to NPRM
COST AND BENEFITS	56018	B4c3p4	1993 WEDI report did not provide data specific to claims attachments, and no reports since that time have attempted to quantify volumes or costs. The report was extremely limited in data for health plans on this subject. In light of existing limitations, we repeat our solicitation for implementation cost information from affected entities. We are providing high-level cost and savings estimates in this proposed rule based on the 1993 data.	This data does not reflect realistic information for the implementation of the rule. It would be better to include the information received from the pilot and extrapolate the cost and savings information.

**Utah Health Information Network  
Claims Attachment NPRM Comments**

AIS/X12 Guide	Issue Identifier	Page Number	Section Number	Text	Comment to CDA
CDA Implementation Guide	Conceptual Approach	2	1.1	This implementation guide describes how to prepare documents for various attachment transactions. It was originally written to provide electronic supporting documentation that is associated with a healthcare claim or encounter, but it may be used for other.	Make this guide available for all exchanges not just for the claim - CDA would be good for many different types of exchanges (i.e. 278, etc).
CDA Implementation Guide	Multimedia Elements	12	2.4.4	The example below illustrates an alternate form of reference. A uniform resource locator (URL) is placed in the REF/@V attribute. The sender uses this form when the multimedia file does not accompany the CDA document and is instead available over the Internet	We recommend removing the URL option from the implementation guide. We recommend that documents be sent in by the provider and should be kept on the payers system with the claim data. There are security and communication issues identified in using external references .
CDA Implementation Guide	Definitions	28	3.1	Need not. The construct ""need not"" indicates a condition or action that is not recommended, but is nonetheless permitted. This construct is equivalent to ""should"" (below), without the sense of endorsing the feature described. An attachment document	Is this definition needed? We recommend the use of Shall and Should in the explanation.

**Utah Health Information Network  
Claims Attachment NPRM Comments**

AIS/X12 Guide	Issue Identifier	Page Number	Section Number	Text	Comment to CDA
CDA Implementation Guide	CE for the Human-Decision Variant	39	3.7.4.2	If the code value would be helpful for a person reviewing the human-decision variant the sender should include the code value as well as a textual explanation of its meaning. This applies particularly to medical codes such as ICD-9-CM, CPT-4 and SNOMED.	This wording needs to reflect that if it exists, then it needs to always be sent with text.
CDA Implementation Guide	DT in the body, Human Decision Variant	41	3.7.6.2	Where the Additional Information Specification calls for a DT (date) data type in the body, the element answer parts shall be included in the PCDATA of the <content> element in a format understandable to a person.	We recommend selecting one date format so there is consistency for the sender and receiver of the CDA.
CDA Implementation Guide	DT in the body, Computer-Decision Variant	41	3.7.6.3	The XML Schema recommendation includes a time-zone designator for dates, although this is of marginal use for attachments. The time-zone designator should not be used. If used, it shall represent the time zone for the time and place where the action being	"should not" is not defined. It appears that this can be used, but should not be used?

**Utah Health Information Network  
Claims Attachment NPRM Comments**

AIS/X12 Guide	Issue Identifier	Page Number	Section Number	Text	Comment to CDA
CDA Implementation Guide	Person Name (PN) Data type	43	3.7.10	CDA attachments shall include the full legal name first among the names when it is available. If the legal name is not available CDA attachments shall include first the primary name that was used for maintaining the patient or provider record in the send	If an individual has only one name (primary name) is this populated in the GIV, MID, FAM, PFX or SFX element? Please clarify.
Clinical Reports Guide  Lab Results Guide	Request for Information versus Request for Service  Request for Information versus Request for Service	3 3	1.5 1.5	In any attachment component answer part it may sometimes be impossible to send a required answer and necessary to send, instead, a reason why the information is not available. In the human decision variant the sender shall supplement the natural language explanation of why the information is not available with local markup. In the computer-decision variant the sender shall include local markup to describe the reason that the information is not available as described in the Data Types section of the HL7 Additional Information Specification Implementation Guide.	We recommend creating LOINC codes for "no response" situations: 1- Not dictated. 2- Results Pending. 3- Service/Test not performed. 4- Service/Test not indicated. 5- Service/Test not ordered. 6- Patient refused Service/Test.  This will make it possible to have a "computer decision variant" response.

**Utah Health Information Network  
Claims Attachment NPRM Comments**

<b>AIS/X12 Guide</b>	<b>Issue Identifier</b>	<b>Page Number</b>	<b>Section Number</b>	<b>Text</b>	<b>Comment to CDA</b>
Clinical Reports Guide	Structure in Clinical Reports	4	1.6	An electronic report that contains structure information must contain the blocks of text together in the sequence in which they appear in the print form of the report. Over time, clinical report attachments with more structure will become more common. For payers that intend to have a human make a decision based on the clinical report, it will be unimportant whether the attachment is largely text or coded in detail in the computer-decision variant. In each case an XML style sheet will support rendering the information for human usage.	Does the provider need to send an electronic report in the sequence order of the printed form report? We would like clarification because there is no standard order/sequence in which the data elements must be sent.

**Utah Health Information Network  
Claims Attachment NPRM Comments**

AIS/X12 Guide	Issue Identifier	Page Number	Section Number	Text	Comment to CDA
Clinical Reports Guide	Report Subject Identifier Codes (with LOINC hierarchy)	6	2.5	Table 2.5, below, provides examples of the more common Clinical Reports request subject codes described in Section 2.1. Note that this table defines a hierarchy. To request all "Clinical-Reports non- lab" use LOINC 26443-2 (the first row in the table) as the subject identifier in the 277 request. To request a more narrow set of reports, use more specific codes further down the hierarchy.	<p>A global request (i.e. 26443-2 Clinical Reports.Non Lab (set)) should not be used when making a request for clinical reports. Providers feel this would overburden their staff to try and find the applicable clinical reports when a global request (i.e. 26443-2) is made.</p> <p>It is recommended to use more specific codes first and the generic codes (i.e. 28562-7 chart sections, 28650-0 Clinical Notes &amp; Chart Sections, etc) next.</p> <p>If only one request can be made (as proposed in the NPRM), providers feel that more generic codes will be used by payers. We would like to see a minimum of 2 requests for attachments and at least 1 and follow up to the requests allowed in the use of the transactions.</p>
Rehabilitation Services Guide	Rehabilitation Services Supporting Documentation	4	2.1	Table 2.1 defines the LOINC codes used to request a complete attachment data set specific to a given rehabilitation treatment plan.	Should this also include laboratory result, diagnostics studies (i.e. table 2.1 emergency department attachments page 5)?

**Utah Health Information Network  
Claims Attachment NPRM Comments**

<b>AIS/X12 Guide</b>	<b>Issue Identifier</b>	<b>Page Number</b>	<b>Section Number</b>	<b>Text</b>	<b>Comment to CDA</b>
Rehabilitation Services Guide	Alcohol-substance abuse rehabilitation service value table	16	3.1	Alcohol-substance abuse rehabilitation treatment plan, medications administered (Composite)	Clarification is needed to know when the medication attachment is used in lieu of the rehab "medication administered" Please include examples.
Rehabilitation Services Guide	HL70162: Route of medicine Administration	59 29	5.2 5.18	Table 5.2 - route of administration; GTT = Gastrostomy Tube  Table 5.18 - route of administration; GTT = Gastrostomy Tube	1- We recommend the use GT or G2, because GTT has a known industry definition. GTT=abbreviation for drops.
Rehabilitation Services Guide	Alcohol-substance abuse rehabilitation service value table	16 21 24	3.1 3.2 3.3	Table 3.1. LOINC code 27524-8 Table 3.2. LOINC code 27461-3 Table 3.3. LOINC code 27792-1	Why specify NDC codes if there is no existing non-proprietary code set, etc. RxNorm may end up being the non-proprietary code set.
Lab Results Guide	General Comment			Today, the most common delivery format of laboratory result messages use HL7 2.x. If providers choose to send attachments electronically, the providers would be required to: 1- scan the laboratory result message, to send an image in the attachment. 2- Translate the applicable laboratory result message attachment into a CDA. Today, the information contained in the HL7 2.x laboratory result messages contains more information than what is contained in the CDA.	We recommend the laboratory result CDA contain the same elements (i.e. including date reported, location performing testing, etc) that are contained in the most frequently used HL7 2.x laboratory result messages. If laboratories choose to send a laboratory result message using CDA, the provider would be able to forward this same laboratory result CDA when this information is requested by the payer.

**Utah Health Information Network  
Claims Attachment NPRM Comments**

<b>AIS/X12 Guide</b>	<b>Issue Identifier</b>	<b>Page Number</b>	<b>Section Number</b>	<b>Text</b>	<b>Comment to CDA</b>
Lab Results Guide	Requirements for sending laboratory results	4	1.7		We recommend that the lab results CDA, is not limit only to claim attachments
Lab Results Guide	Laboratory Results Supporting Documentation	8	3.1	Table 3.1 - LOINC Report Subject Identifier Codes	<p>We recommend that the payer be specific with the request.</p> <p>We recommend that there be ability to lookup specific requests within the RELMA tool. With the ability to display specific test and which report subject it is under.</p>
Lab Results Guide	Laboratory Results Supporting Documentation	8	3.1	Table 3.1 - LOINC Report Subject Identifier Codes	We recommend using the most specific level in requesting laboratory results.
Lab Results Guide	RELMA tool			Do we also want the long name of the test instead of just the short name which includes abbreviations?	In the "view HIPAA attachment" section of the RELMA tool provide a search function. Recommend also including the long name of the test. Not all payers and provider and provider staff may know the abbreviations in the short name description.
Lab Results Guide	Human-decision variant, XML Body	5	2.1	L)	We recommend selecting one date format so there is consistency for the sender and receiver of the CDA.

**Utah Health Information Network  
Claims Attachment NPRM Comments**

<b>AIS/X12 Guide</b>	<b>Issue Identifier</b>	<b>Page Number</b>	<b>Section Number</b>	<b>Text</b>	<b>Comment to CDA</b>
Lab Results Guide	Human-decision variant, XML Body	6	2.1	M)	<p>We recommend creating LOINC codes for "no response" situations:</p> <p>1- Not dictated.  2- Results Pending.  3- Service/Test not performed.  4- Service/Test not indicated.  5- Service/Test not ordered.  6- Patient refused Service/Test.</p> <p>This will make it possible to have a "computer decision variant" response.</p>
Lab Results Guide	Human-decision variant, XML Body	6	2.1	O) Comments that apply to an entire section be specific of where this should be located	Please clarify if this is only at the top or only at the bottom of the battery.
Medications Guide	Usage Scenarios	4	1.6	Separate LOINC codes exist to request information (i.e. current medications, medications administered, and discharge medications)	We like the flexibility of the different LOINC codes to request information (i.e. current medications, medications administered, and discharge medications). These LOINC codes have a potential high volume use for other uses (i.e. prior auth, case management, etc)
Medications Guide	Special Considerations for the Drug Codes	5	2.1	No existing, non-proprietary code set is ideal for sending drug information in attachments.	Why specify NDC codes if there is no existing non-proprietary code set, etc. RxNorm may end up being the non-proprietary code set.

**Utah Health Information Network  
Claims Attachment NPRM Comments**

<b>AIS/X12 Guide</b>	<b>Issue Identifier</b>	<b>Page Number</b>	<b>Section Number</b>	<b>Text</b>	<b>Comment to CDA</b>
Medications Guide	Special Considerations for the Drug Codes	5	2.1	This specification is written in a manner to work as well as possible with whatever codes may be defined in regulations or, in non-regulated applications. In particular the coding system for identifying drugs is not specified herein. This specification requires that the print name of a selected drug always be sent, whether or not a code identifying the drug is sent.	We recommended that abbreviations for the drug name are not used. Print the full drug name.
Medications Guide	LOINC codes for Report Components	11 12 14	3.3 3.3 3.3	Table 3.3. LOINC code 18606-4, 18618-9, 18611-4 (Medication current, name + identifier) and 18607 (medication current, dose)	Why specify NDC codes if there is no existing non-proprietary code set, etc. RxNorm may end up being the non-proprietary code set.
Medications Guide	HL70162 Route of Medication Administration	23	5.3	Table 5.3 - route of administration; GTT = Gastrostomy Tube	1- We recommend the use GT or G2, because GTT has a known industry definition. GTT=abbreviation for drops.

**Utah Health Information Network  
Claims Attachment NPRM Comments**

AIS/X12 Guide	Issue Identifier	Page Number	Section Number	Text	Comments to CDA
275 (x151.pdf)Guide	Associated Data Transaction Set 102	F.1			<p>This transaction does not seem to be applicable to the HL7 CDA, which is proposed in the attachments NPRM. It appears to be applicable to HL7 2.x messaging.</p> <p>We recommend that this document be updated or else removed.</p>

**Utah Health Information Network  
Claims Attachment NPRM Comments**

UHN agrees with the following joint HL7 and X12 comments

Comment Section	HL7 Comment to CMS
<p>II, C, 2 Overview of Clinical Document Architecture</p>	<p style="text-align: center;"><b>Joint Comment with X12</b></p> <p><b>HL7 Comment:</b></p> <p>HL7 and X12 have collaborated on the following topic and submit this joint response:</p> <p>Comment 1: HL7 and X12 recommend moving to CDA release 2, assuming that there is a pilot that uses CDA release 2. Additionally we note that HL7 will need changes to the HL7 IG and each AIS developed to be based on CDA release 2. HL7 has every intention of making all necessary specification changes in as timely a manner as is possible.</p> <p>Comment 2: The benefits of using CDA Release 2 would be:</p> <ol style="list-style-type: none"> <li>1. More technical consistency with all new standards coming from HL7 including, but not limited to genomic reporting, adverse event reporting, and CDA implementation guides, including the Care Record Summary.</li> <li>2. More consistency with code being developed by EHR developers (vendors and users) for standard and other applications based on the CDA</li> <li>3. More ability to use off-shelf software being developed by health care vendors</li> <li>4. Improved technology for validating computer-decision variant instances of attachments (when this is required)</li> <li>5. Compliance with the U.S. Federal Consolidated Healthcare Informatics initiative</li> <li>6. Providers who implement EHRs would benefit from CDA release 2 because they could take advantage of commercial off-the-shelf software (COTS) solutions in their EHRs to create the electronic attachments. Most EHR vendors are developing CDA R2 implementations and not CDA R1 implementations.</li> <li>7. Military Health System Enterprise Wide</li> </ol>

**Utah Health Information Network  
Claims Attachment NPRM Comments**

Comment Section	HL7 Comment to CMS
	<p>Referrals and Authorizations will use X12 278/275 and CDA Release 2.</p> <p>8. R2 HDV no more complex than R1 HDV.</p>
<p>III. Modifications to Standards ,A &amp; B. 1<sup>st</sup> paragraph</p>	<p><b>Joint Comment with X12</b></p> <p><b>HL7 Comment:</b></p> <p>HL7 and X12 have collaborated on the following topic and submit this joint response:</p> <p><u>Comment 1:</u> Our main goal is to move the regulatory process forward more quickly. For new attachment types* (AIS), we recommend that the DSMO be authorized to adopt those that are developed, balloted and published by HL7 through the DSMO process. Stop the process here and do not go through the full regulatory process.</p> <p>This overall process will include provisions for outreach and comments in the HL7 SDO processes. In addition, notification and rollout time between adoption and implementation date needs to be added after the HL7 publication. More time is needed to implement new types than for changes to existing ones.</p> <p><u>Comment 2:</u> Our main goal is to move the regulatory process forward more quickly. For <i>new versions</i> of standards by HL7 or X12, we recommend that the DSMO be authorized to adopt those that are developed, balloted and published by HL7 or X12 through the DSMO process. Stop the process here and do not go through the full regulatory process.</p> <p>This overall process will include provisions for outreach and comments in the SDO processes. In addition, notification and rollout time between adoption and implementation date needs to be added after publication. Provisions for sunseting older versions of the standards after a transition period must be included.</p> <p>Additionally HL7 and X12 recommend that the Implementation timeframes of new HL7</p>

**Utah Health Information Network  
Claims Attachment NPRM Comments**

<b>Comment Section</b>	<b>HL7 Comment to CMS</b>
	<p>AIS booklets should allow six months, minimum, for new attachment types, and 12 months for new versions of existing attachment types. The timeframe begins once the DSMO has completed its review/approval process.</p> <p>Attachment types currently in varying stages of development, but not named in the Final Rule include EAP, DME, CPHS, Periodontal, Home Health, and Consent Forms.</p>
	<p><b>HL7 Comment:</b> 'LOINC modifier' must be specifically cited in Sections 162.1915 and 162.1925.</p> <p>DISCUSSION items included:</p> <ul style="list-style-type: none"> <li>a. one reference to LOINC modifier in the preamble</li> <li>b. the modifier does go back in the STC of the 275</li> </ul>
	<p><b>HL7 Comment:</b> HL7 recommends that LOINC and LOINC modifiers should be included in the definition section of the preamble of the Final Rule.</p>
Last paragraph	<p><b>HL7 Comment:</b> The examples cited in the preamble are not modifiers used in the six proposed attachments. LOINC modifiers used in claims attachments are the time-window modifiers and item-selection modifiers. HL7 recommends the examples in the Final Rule reflect the appropriate use of modifiers for the claims attachments business use.</p>
Overview of Extensible Markup Language (XML)	<p><b>HL7 Comment:</b> The preamble of the NPRM references style sheets incorrectly and HL7 recommends clarifying this in the Final Rule. The individual attachment AIS's (booklets) do not include a stylesheet; the stylesheet is provided separately by HL7. It should also be noted that at this time, one style sheet works for all 6 attachment types.</p>
162.1920	<b>HL7 Comment:</b>

**Utah Health Information Network  
Claims Attachment NPRM Comments**

<b>Comment Section</b>	<b>HL7 Comment to CMS</b>
Electronic healthcare claims attachment response transaction	<p>HL7 and X12 have collaborated on the following topic and submit this joint response:</p> <p>HL7 and X12 recommend that this section be named "Electronic healthcare claims attachment transaction." We recommend removing "response" from the section title as well as any of the paragraphs in that section. Since the 275 attachment transaction is not always sent in response to a request, it is more appropriate to refer to it as the "attachment transaction." Additionally, we point out that in paragraph (e) the regulation refers to an unsolicited response transaction. If the 275 is being sent in an unsolicited mode, it is not a response. We recommend referring to the "unsolicited attachment transaction" in this paragraph.</p>

**Submitter :**

**Date: 01/21/2006**

**Organization :**

**Category : State Government**

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Request for HL7 to add additional codes to a variety of code sets.

Additional Information Specification 0004 Clinical Reports Attachment:

Table 2.5 Loinc Report Subject Identifier Codes

Please add a code for Tooth Map

Table 3.3.2, Operative Note

Please add Assistant Surgeon and Inplant Information.

Table 3.4.1, Cervical Spine X-Rays

Please add what view was taken in the X-Ray.

Table 3.4.2 - CT Study Head

Table 3.4.3 - CT Study Extremity

Table 3.4.4 - MRI Head Study

For all three of these tables, please add contrast information, was contrast used or not, what kind of contrast, etc.

Additional Information Specification 0001: Ambulance Service

Please add Wait Time Reason.

If "Other", a descriptive reason must be given.

Table 5.2, HL7 Reason for Scheduled EMS Trip

Please add

Higher level of care

Other Eye

Other Surgery

Other Dental

Table 5.5, HL79010: HL7 Medical Reason for Unscheduled Trip

Please add:

Higher level of care

Eye

Surgery

Dental

Care Not Available at this Facility

**Submitter :** Ms. Trudy Solomon  
**Organization :** SC Hospital Association  
**Category :** Health Care Professional or Association

**Date:** 01/23/2006

**Issue Areas/Comments**

**GENERAL**

GENERAL

We concur with the comments submitted On November 22, 2005 by the American Hospital Association.

**Submitter :** Kristina Pelletier  
**Organization :** TRICARE Management Activity  
**Category :** Federal Government

**Date:** 01/23/2006

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-0050-P-113-Attach-1.PDF

HIPAA Claims Attachment NPRM  
January 19, 2006

NPRM Claims Attachment Section Header	Page	Comment	Justification
<b>General</b>			
		The Initial Six Additional Information Specifications (AIS) should be adopted as standards.	
ASC X12N/005010X211 document titled "Additional Information to Support a Health Care Services Review (275)" and dated SEPTEMBER 2005		All examples of segment EFi, position 15 read "(EFi15)," this seems to be an error.	
<b>Impact of the Privacy Rule</b>			
	55999	Recommend that HHS provide added guidance related to privacy and security, not just "minimum necessary."	
<b>Connection to Signatures (Hard copy and Electronic)</b>			
Subsection Paragraph 6	56000	An important tool in detecting fraud is being able to identify who actually performed the service by identifying who signed the clinical record (i .e. office notes, operative notes, radiological interpretations, etc) and comparing the finding to who is billing for the service. In these types of fraud instances, the signature becomes the evidence or proof of fraud. It is probable that for the providers who choose to scan, or image their clinical records that the signatures will be identifiable. The concern lies with the provider(s) who manually enter clinical record data into a conversion utility, or use an EMR. a. Since anyone can enter an electronic signature, it would not prove who actually performed a service. How is the signature denoted?	

**Submitter :** Dr. Walter Suarez  
**Organization :** Midwest Center for HIPAA Education  
**Category :** Health Care Professional or Association

**Date:** 01/23/2006

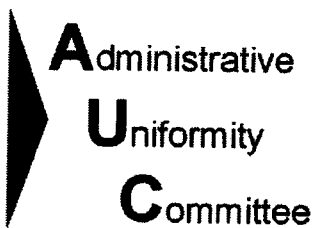
**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-0050-P-114-Attach-1.PDF



January 20, 2006

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
CMS-0050-P

HIPAA Administrative Simplification: Standards for Electronic Claims Attachments

Dear Sir/Madame:

On behalf of the members of the Administrative Uniformity Committee and the Minnesota HIPAA Collaborative, I would like to formally submit our comments on the Notice of Proposed Rule Making (NPRM) for the establishment of national standards for electronic claim attachments (CMS-0050-P) published in the September 23, 2005 issue of the *Federal Register*.

All of our comments are presented in the attached document, which has been organized into the various appropriate comment sections, per the instructions provided in the NPRM. For ease of review, we have listed for each comment the *Federal Register* page/column reference, a summary of the issue and our comments, and any corresponding recommended modifications to the proposed rule language.

We have also included with these comments a document summarizing the results of a survey on claim attachment practices and perspectives conducted among Minnesota's largest payers and providers. The intent of the survey was to provide additional evidentiary support for the comments and recommendations contained in our master comment document.

Allina Hospitals and Clinics ∨ American Association of Healthcare Administrative Management ∨ Blue Cross Blue Shield of MN ∨ Children's Hospitals and Clinics ∨ Delta Dental Plan of MN ∨ Fairview Hospital and Health Care Services ∨ HCPCS Committee ∨ Health Care Payer and Provider Advisory Council ∨ HealthEast ∨ HealthPartners ∨ Hennepin County Medical Center ∨ Hennepin Faculty Associates ∨ Mayo Clinic ∨ Medica Health Plan ∨ Metropolitan Health Plan ∨ MN Dental Association ∨ MN Department of Health ∨ MN Department of Human Services ∨ MN Department of Labor and Industry ∨ MN Hospital Association ∨ MN Medical Association ∨ MN Medical Group Management Association ∨ MN Pharmacists Association ∨ MN Uniform Billing Committee ∨ Noridian Administrative Services, L.L.C. - Medicare Part A ∨ Park Nicollet Health Services ∨ PreferredOne ∨ St. Mary's/Duluth Clinic Health System ∨ UCare MN ∨ University of Minnesota Physicians ∨ Wisconsin Physician Services - Medicare Part B

Visit our website at: [www.mmaonline.net/auc](http://www.mmaonline.net/auc)

We would like to take the opportunity in this cover letter to highlight a few overarching points regarding the proposed rule:

1. Overall, we would like to state our strong support for the efforts undertaken by CMS to establish new national standards for the electronic submission of health care claim attachment information. We believe the industry will benefit significantly from the establishment and adoption of some of these new standards.

At the same time, there are a number of important issues that we believe will need to be addressed before the final decision is made regarding the adoption of these standards. Among them:

- A significant **lack of knowledge and understanding** among vast segments of the health care industry regarding the claim attachment transaction and the proposed claim attachment standards.
- A noticeable **lack of experience** (both at the testing and operational levels) in the health care industry with the use and implementation of electronic claim attachment transactions and, particularly, with the proposed standards and code sets. Only a relatively limited number of pilots are currently underway, and only on certain types of claims attachments.
- **Limited documented information about cost-benefit analysis and return on investment** associated with the adoption and use of these standards by the health care industry.
- **No hard data documenting the actual volume** of transactions in the health care industry today that require additional information, for each of the claim attachment types being proposed (or for others not included in the initial set).

With all these pieces of information missing or only available through extrapolations from other EDI-related experiences or through very limited pilot data, we believe CMS should make a very careful evaluation and consideration about the adoption of each of the proposed standards vis-à-vis the need to better document, pilot test and evaluate them.

2. We strongly recommend that CMS, in coordination with other national and regional groups, conduct a more comprehensive assessment of the use of claim attachments (by type), the business processes, methods and formats utilized, and the cost and benefits realized from its adoption.
3. Another very important issue we believe will need to be addressed is the impact that these new standards will have on small and medium size urban and rural health care provider organizations. Today, many of these organizations submit claim attachment information 'electronically' via alternate methods. We are specially concern with the unknown impact and unforeseen, undesirable effects that the adoption of the standards will have on these small and medium-size providers and the transition they will need to go through to be capable of submitting these attachments using the adopted standards. Many of them might resort to going back to using paper or other non-electronic submissions.

4. While we support the use of the proposed X12 transactions for the transmission of electronic claim attachments, we strongly recommend the adoption of version 5010 of these X12 transactions, rather than the version 4050 proposed in the NPRM. We believe the issues already identified with the proposed version 4050 by the developers would be resolved by moving to the version 5010 of these standards. If so, we recommend that the industry be given an opportunity to review and comment on those standards prior to its final adoption, perhaps through the issuance by CMS of an interim rule (rather than a final rule) after the current comment period is completed.
5. Based on the results of our Minnesota Survey on Claim Attachments, we strongly recommend that the adoption of these standards be done on a phased approach, starting with the Clinical Reports claim attachment type and the Laboratory claim attachment type. The adoption of the other four proposed standard claim attachment types should be done down the road, once the elements discussed above (documentation of use, testing, experience, cost-benefit analysis) are completed.

One of the most significant findings from our survey that supported this recommendation was the fact that among the largest Minnesota payers (not including Medicare), none of the Emergency Department claims, Rehabilitation claims or Medications claims require an attachment at this point, and only less than 2% of all ambulance claims require an attachment. This documented fact in the Minnesota market raises concerns about the knowledge and understanding in the nation of the actual volumes of these proposed attachments, and the true cost-benefit of adopting such standards.

6. We believe there are two areas not covered by HIPAA that require a significantly higher numbers of attachments to be submitted by providers: Workers' Compensation and Motor Vehicle claims. We are very concerned that with the adoption of new standards for claim attachments, providers will need to maintain dual claim attachment systems, one to comply with HIPAA and another to fulfill the claim attachment format and content requirements of Workers' Compensation and Auto Insurance.
7. We would like to strongly recommend that the regulations prohibit payers, including Medicare, from requiring the use of any of these standards, if adopted, prior to their respective compliance dates.
8. Finally, over the past few years the industry has been moving away from requiring attachment information for certain types of claims, given that the information is (or can be) provided on the electronic claim standard itself. This, in our view is consistent with the goals of administrative simplification. We are very concern about the effect that establishing certain claim attachment standards now will have on this trend, and the possibility that the industry will begin to 'go back' to requiring more claim attachments and even consider eliminating certain data elements from the current claim because they would exist on a claim attachment standard.

Along these lines, we would like to confirm that the use of the X12N 275 transaction along with the X12N 278 transaction is going to be permitted.

### **About the Minnesota Administrative Uniformity Committee**

The Administrative Uniformity Committee (AUC) is a broad-based group representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The mission of the AUC is to develop agreement among Minnesota payers and providers on standardized administrative processes when implementation of the processes will reduce administrative costs.

### **About the Minnesota HIPAA Collaborative**

The Minnesota HIPAA Collaborative was formed to help Minnesota providers and health plans achieve timely and cost-effective implementation of the HIPAA transactions, codes, and identifier standards (not privacy and security). The Collaborative will promote HIPAA transaction readiness, identify recommended practices and recommend solutions. The Minnesota HIPAA Collaborative consists of Minnesota health plans and providers. The Collaborative is independent and not associated with any professional organization.

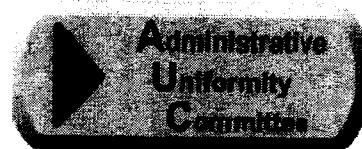
If you have questions about any section of our response please do not hesitate to contact Kristin Loncorich from the Minnesota Department of Health at (651) 282-6343 or via email at: [Kristin.Loncorich@state.mn.us](mailto:Kristin.Loncorich@state.mn.us).

Sincerely yours,

*[ORIGINAL SIGNED]*

Gretchen Thomson  
Chair, Administrative Uniformity Committee  
St. Mary's/Duluth Clinic

/enclosures



MEETING THE CHALLENGE...  
**MN HIPAA COLLABORATIVE**  
...OF HIPAA TRANSITION

*MINNESOTA COMMENTS ON THE*  
*NOTICE OF PROPOSED RULE MAKING ADOPTING STANDARDS FOR*  
*ELECTRONIC HEALTH CARE CLAIM ATTACHMENTS*

**45 CFR Parts 162**  
**[CMS-0050-P]**

*SUBMITTED TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)*  
*U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES*

A REVIEW PROCESS FACILITATED BY  
THE MIDWEST CENTER FOR HIPAA EDUCATION



**January 20, 2006**

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
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## **SECTION II - PROVISIONS OF THE PROPOSED REGULATIONS**

### **SECTION II-A - DEFINITIONS**

1	55993/3	<p>We generally agree with the list of new terms and the proposed definitions for those terms.</p> <p>We believe there are differences in the way terms are described in the preamble text and defined in the text of the rules. We strongly recommend reviewing the preamble description of all definitions and conforming them to the actual text of the rule.</p>	
2	55993/3	<p>The definition of the term "Attachment Information" should include the word "needed to support the <u>adjudication</u> of a claim..."</p> <p>We also recommend that a definition be added for the term 'post-adjudication'. We have concerns that the concept of post-adjudication is frequently used in the rule and should be defined.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
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**SECTION II-B - EFFECTIVE DATES**

3	55994/2	<p>We have strong concerns about requiring a common implementation date of the proposed standards for all six claim attachment types being proposed in the regulation. The concurrent transition and implementation of all six standards during a 2-year period after the effective date of the final rules seems especially hard, given other competing requirements, the cost of implementation, and the lack of clear ROI models.</p> <p>Throughout the NPRM, CMS made emphasis on the following four concerns:</p> <ul style="list-style-type: none"><li>■ Need to identify priority claims that most commonly require some type of attachment to be processed.</li><li>■ Need to gain experience with a manageable number of electronic attachment types.</li><li>■ The critical role that pilot programs and early testing play in the standards adoption process.</li><li>■ The fact that the Additional Information Specifications (AIS) documents were developed several years ago, when business practices for claims attachments were different.</li></ul> <p>Given these concerns, we strongly recommend that rather than establishing a common deadline for all six claim attachment types, a sequential deadline plan be put in place, to progressively adopt the six standards. Having an 'implementation period' rather than a single deadline, will allow the industry to plan, test, transition and implement each of the proposed claim attachment types, something that has not yet been fully done and documented.</p>	
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Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
		Based on the results of our Minnesota Survey on Claim Attachments, <b>we strongly recommend that the adoption of these standards be done on a phased approach, starting with the Clinical Reports claim attachment type and the Laboratory claim attachment type.</b> The adoption of the other four proposed standard claim attachment types should be done down the road, once the elements discussed in our cover letter (documentation of use, testing, experience, cost-benefit analysis) are completed.	
4	55994/2	<p>Other comments on this point:</p> <ul style="list-style-type: none"> <li>■ We believe there is a need to conduct a more comprehensive survey to determine the most appropriate implementation sequencing order for adoption and compliance.</li> <li>■ CMS should consider also establishing an earlier implementation deadline for Health plans and Clearinghouses, and a later one for providers.</li> <li>■ It is specially noticeable that the complexity of each of the six claim attachment types is even greater, when considering that the standard that defines each proposed type (specifically, the clinical report type) includes many data sets to address various situations/scenarios. All in all, there are over 20,000 data elements/codes involved in these proposed standards.</li> <li>■ We would like to strongly recommend that the regulations prohibit payers, including Medicare, from requiring the use of any of these standards, if adopted, prior to their respective compliance dates.</li> </ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
5	55994/2	<p>With respect to the applicability of the rule, we request clarification as to the applicability of the rule to covered entities (covered health care provider, health plans and clearinghouses) and whether all covered entities DO HAVE A CHOICE to conduct claim attachments electronically, or only covered providers, as is the case with the other 8 HIPAA adopted standards for administrative transactions, where plans and clearinghouses are <b>required to be ready to accept</b> the electronic transaction, if a provider had chosen to submit that transaction electronically. Are health plans and clearinghouses forced to be ready to accept an electronic claim attachment, even if the provider has chosen to submit the claim attachment on paper?</p> <p>The language under § 162.1905 Requirements for Covered Entities - page 56024/1 states that: "...When using electronic media to conduct a health care claims attachment request transaction or a health care claims attachment response transaction, a covered entity must comply with the applicable standards of this subpart..."</p> <p>See more information regarding this point below (comment on page 60001 column 1).</p>	

**SECTION II-C - OVERVIEW OF KEY INFORMATION FOR ELECTRONIC HEALTH CARE CLAIMS ATTACHMENTS**

6	55995/1	<b><u>1. Overview of Extensible Mark-up Language (XML)</u></b>  No comment.	
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Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
7	55995/3	<p><b><u>2. Overview of Clinical Document Architecture</u></b></p> <p>While we do not have the technical expertise to comment on the pros and cons of each CDA (Clinical Data Architecture) release, we are concerned that the AIS reference documents for the six claim attachment types are based on a CDA that, by the time the claim attachment standards are expected to be required, the CDA Version 1.0 might be already 10 years old, and not supportive of the changing business needs, claim attachment requirements and clinical data exchange expectations.</p> <p>We do not have the expertise or the content details on the style sheets to comment on their ability to permit the use of either CDA release, by creating a cross-walk between different releases, nor we have hard data on the costs and timing associated with implementing one release version over the other.</p>	
8	55995/3	<p><b><u>3. How XML Is Applied Within the Clinical Document Architecture</u></b></p> <p>No comment.</p>	
9	55996/1	<p><b><u>4. Transactions for Transmitting Electronic Attachments</u></b></p> <p>We strongly support the use of the proposed X12 transactions for the transmission of electronic attachments:</p> <ul style="list-style-type: none"> <li>■ X12 277 for the electronic transmission of a request for claim attachment information.</li> <li>■ X12 275 for the electronic transmission of a response to a claim attachment request for information.</li> </ul> <p>We strongly recommend the adoption of version 5010 of the propose X12 transactions, rather than the version 4050, as proposed in the NPRM.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
10	55997/1	<p><b><u>5. Electronic Claims Attachment Types</u></b></p> <p>Issue No. 1 - Are these six the priority ones to focus on at this time?</p> <ul style="list-style-type: none"> <li>■ We concur with CMS' own comment on the NPRM that "...The effect of adopting a limited number of attachments at first is to give industry more time to gain experience." That is why we question the reasoning behind adopting all six types of claim attachments at once. We strongly recommend that CMS considers adopting two or three of the types first, then the others. This is particularly true as it seems there is very little or none experience even at the pilot level with some of these claim attachment types.</li> <li>■ For example, when the 8 HIPAA transactions were adopted, most of them, if not all of them, were already in production and being used (albeit, earlier versions of them - 3051, 3070, etc) , but at least the industry had production-level experience with the standards (X12), the actual transactions (claims, claim payment, etc), the code sets (ICD, CPT, etc). It seems that with these propose claim attachment types, there is very little experience with the combination of standards (X12+HL7), the actual use of the AIS documents for the six claim attachment types themselves, and the codes sets being proposed.</li> </ul> <p>MN Claim Attachment Survey Results Comment:</p> <ul style="list-style-type: none"> <li>■ One of the most significant findings from our survey was the fact that among the largest Minnesota payers (not including Medicare), none of the Emergency Department claims, Rehabilitation claims or Medications claims require an attachment at this point, and only less than 2% of all ambulance claims require an attachment. This documented fact in the Minnesota market raises concerns about the knowledge and understanding in the nation of the actual volumes of these proposed attachments, and the true cost-benefit of adopting such standards.</li> <li>■ Rehab. therapy supplemental information is done almost 100% of the time on a prior authorization basis, and not as an attachment to claims.</li> </ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
11	55997/1	<p><b><u>5. Electronic Claims Attachment Types (cont.)</u></b></p> <p>Issue No. 2 - What are the other priority ones to focus on over the next 5-10 years? The ones listed in the NPRM are: 1) DME; 2) Home Health; 3) Periodontal Care; 4) Consent; 5) Secondary Payer Questionnaire?</p> <p>We believe that there are going to be other attachment types in today's industry processes that are higher priorities, but for which no standard has yet been developed or approved. We would like to see the adoption of those move faster (i.e. DME and Consent From, which show large volumes of use).</p> <p><u>MN Claim Attachment Survey Results Comment:</u></p> <p>Among the next priority attachments, our survey found:</p> <ul style="list-style-type: none"> <li>■ Durable Medical Equipment and Home Health being the most critical ones, followed by Children's Preventive Health Services and Secondary Payer Questionnaire, and Consent and Periodontal Services ranked third.</li> <li>■ We also asked about a list of other claim attachment types and how important they were. Following are the top 5 'other' types: <ul style="list-style-type: none"> <li>○ EOB/EOM; Itemized Bills; COB Information; Certificate/Letter of Medical Necessity; and Federal/State Mandated Forms for Medicare/Medicaid.</li> </ul> </li> <li>■ In some cases, the volume of these 'other' claim attachment types is much higher than the initial set being proposed by the regulations.</li> </ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
12	55997/1	<p><b><u>5. Electronic Claims Attachment Types (cont.)</u></b></p> <p>Issue No. 3 - Impact on servers/storage systems for processing/storing claim attachment information</p> <ul style="list-style-type: none"> <li>■ It seems, from the review of the pilot projects (specifically the Empire pilot), that the file sizes of claim attachments are not a trivial issue, both for purposes of storage as well as transmission speed of data (this second point seem to be the biggest issue at this point - even if connections are high-speed, transmitting very large files could take several minutes, which would be an issue for organizations).</li> <li>■ We believe that without having Electronic Medical Records in place, the data being transmitted will continue to be too contained in files that are too large.</li> </ul>	
13	55997/1	<p><b><u>5. Electronic Claims Attachment Types (cont.)</u></b></p> <p>Other comments:</p> <ul style="list-style-type: none"> <li>■ Government should facilitate a more comprehensive survey involving larger number of providers, payers, vendors, on each specific claim attachment separately, to assess priority areas for claim attachment needs now and in the future.</li> </ul>	
14	55997/2	<p><b><u>6. Format Options (Human vs. Computer Variants) for Electronic Claims Attachments</u></b></p> <p>No comments.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
15	55998/1	<p><b><u>7. Combined Use of Two Different Standards Through Standard Development Organization (SDO) Collaboration</u></b></p> <p>We support the proposed combined use of ASC X12N and HL7 standards for the transmission of claim attachment information. We are concerned, as we have expressed in various other sections of these comments, about the lack of industry experience, even at the basic piloting level, let alone at the production level, with the combination of these two standards. We believe it is imperative that more extensive piloting be done, with defined measurable outcomes on technical, business, administrative and ROI issues/expectations.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
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**SECTION II-D - ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT BUSINESS USE**

16	55998/3	<p><b><u>General</u></b></p> <p>Issue No. 1 - Payers will have to create tables to define exactly what they request that is not on a standard claim.</p>	
17	55998/3	<p><b><u>General</u></b></p> <p>Issue No. 2 - 'Pending' claims:</p> <p>We request clarification on whether the NPRM language is requiring the 'pending' of claims, while waiting for a 277 to be sent.</p> <p>There are differences between payers on how they handle denied claims. Some payers will deny and close a claim, and a new claim will be generated. Some will deny and 'reopen' using same claim ref information. Some deny and when a duplicate is sent a new claim number is assigned. This creates different practices to send the attachment:</p> <ul style="list-style-type: none"> <li>■ Send a brand new claim, with the attachment.</li> <li>■ Send exact claim, with attachment.</li> <li>■ Send only the attachment.</li> </ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
18	55998/3	<p><u>General (cont.)</u></p> <p>Issue No. 3 – Post-adjudication information request:</p> <p>The NPRM states that "...Although additional clinical or administrative information may be required following adjudication of claims, such as for post-adjudication review to support quality control, fraud and abuse, or other post-adjudication reviews and reporting requirements, we do not consider these post-adjudication requests for claims-related data to be part of the claims payment process. Therefore, post-adjudication processes are not covered by this proposal."</p> <p>Is it then permissible to use claim attachment information for non-adjudication/post-adjudication purposes? For example data being required for federal reporting (example of Medicare Sterilization Consent). The NPRM seems to allow the use of claim attachment info for non-adjudication (in a post-adjudication process). It also seems that 'attachment-like' information can be requested for non-claim adjudication related purposes, and providers/payers are able to either use or not use the standard.</p> <p>We request clarification and guidance on what will be allowable and what is not with respect to collection and use of claim-attachment-like information for post-adjudication and non-adjudication related processes. Leaving it open will create variability for providers. On the other hand, closing too stringently will create a need for payers to have to re-negotiate contracts – which means there will be a need for more than just 24 months for compliance.</p> <p>We also recommend that a definition be added for the term 'post-adjudication'. When does post-adjudication start?</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
19	55998/3	<p><b><u>General (cont.)</u></b></p> <p>Issue No. 4 - 'Pending' claim, 'Denied' Claims and the use of the 835 vs a 277:</p> <p>We are concerned that the rules might be requiring the industry to move from using the 835 to using the 277 when a claim is pended or denied and the 835 contains an explanation code that points to the need for additional information. What instances would be acceptable to use a standard 835 to communicate to a provider that the claim has been denied pending submission of additional information, and what instances would require the submission of a 277 - request for claim attachment information?</p> <p>We strongly request that clarification be provided on this point.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
20	55999/1	<p><b><u>1. Electronic Health Care Claims Attachment vs. Health Care Claims Data</u></b></p> <p>In the NPRM, it is said that "Electronic health care claims attachments must not be used to convey information that is already required on every claim. Information needed for every claim is "claims data" that must be conveyed in the appropriate standard claim transaction." Furthermore, in the actual propose rule text (page 56024) § 162.1905(a) states "...information not contained in a health care claim is needed for the adjudication of that health care claim:..."</p> <p>We request clarification as to the use of the term 'every' in both sentences. We are concerned that the industry is still struggling somewhat to determine what a valid and complete 837 is, it will be even more challenging to define what data is or isn't claim data. There is also the difference between data when a claim is submitted electronically vs paper, and neither the rule text nor the text in the preamble seem to address these data content differences.</p> <p>Also, we believe the use of the words "not contained" in the actual rule text, same as above, creates ambiguity with the required vs. situational data conditions used in the electronic transactions.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
21	55999/1	<p><b><u>2. Solicited vs Unsolicited Electronic Health Care Claim Attachments</u></b></p> <p>We strongly support the use of the unsolicited electronic claim attachment submission method. We believe this is where the most significant benefit will be derived from. We don't believe that the current proposed practice of waiting for 277 to send a 275 is the most efficient way.</p> <p>On Column 2 - Language used in NPRM refers to "payer instructions" rather than "provider payer collaboration and agreement on what is necessary" in advance through <u>normal</u> trading partner relations.</p> <p>We support the concept that submission of unsolicited attachments must be 'pre-arranged', 'pre-determined' or following pre-established business rules between trading partners. Providers cannot send unsolicited without the pre-arrangement.</p> <p>While we support the concept of having health plans only be able to solicit one attachment transaction with all desired elements known to be needed at the time, it will be important to note that in some limited circumstances, health plans after receiving the initial attachment might need to require submission of additional information.</p> <p>We understand that the rules in fact prohibit the submission of a 'true' unsolicited claim attachment (primarily because of inconsistency with the privacy rule).</p> <p>We request that confirmation be made that if an unsolicited claim attachment is being sent electronically (after advance instructions have been established), that the adopted electronic standard claim attachment submission be the one required to be used. We believe this point is not made clear in either the preamble or the regulation text.</p>	<p><b>§ 162.1920 Electronic health care claims attachment response transaction.</b></p> <p>(a) The health care claims attachment response transaction is the transmission of attachment information, from a health care provider to a health plan, in response to a request from the health plan for the information <u>whether the request is done through an electronic health care claim attachment request described at § 162.1915, the advanced instructions, specified at § 162.1920 (e), or other non-electronic request methods.</u></p>

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
22	55999/1	<p><b><u>2. Solicited vs Unsolicited Electronic Health Care Claim Attachments (cont.)</u></b></p> <p>We also strongly support the proposed language intended to 1) impede a prolonged back-and-forth data request/response process between health plans and providers; 2) restricting health plans from extending adjudication through a lengthy process of multiple individual attachment requests for the same claim; and 3) restricting health care providers from being able to send bits and pieces of the requested information at different times or dates.</p>	
23	55999/1	<p><b><u>2. Solicited vs Unsolicited Electronic Health Care Claim Attachments (cont.)</u></b></p> <p>We are concern about the possible interpretation that some entities might give to the unsolicited language in the NPRM, to mean that the payer has to authorize the use of unsolicited 275s, and that if they don't support them, they will have the ability to reject them.</p> <p>We would like to recommend that the final rule make it clear that if a payer received electronic attachment types, that they are required to support unsolicited 275s as well.</p> <p>We believe that the discussion between the payer and the provider should focus around <u>how</u> and <u>when</u> the provider would send them. As is evidenced in our supportive comments about the unsolicited form of submission of claim attachments, we strongly believe the big ROI for providers and health plans is found in these unsolicited forms (albeit, pre-arranged between the payer and provider) and not the other method where the payer has to program to send out the 277 first.</p> <p>We strongly believe that payers, included Medicare, should not be able to exclude themselves from supporting unsolicited claims.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
24	55999/2	<p><b><u>3. Coordination of Benefits</u></b></p> <p>Questions:</p> <ul style="list-style-type: none"> <li>■ Can a payer pass information to another – without violating minimum necessary?</li> <li>■ Can a provider send all information to all payers, regardless if one of them doesn't need/expect the data – without violating minimum necessary?</li> <li>■ Plan to Plan COB – second payer might still need a piece of attachment information that first payer didn't have/collected – How would the secondary payer collect the data? Going to the provider directly.</li> <li>■ We support the preamble explanation that a secondary health plan will not be limited to the claim attachment information requested by a primary health plan, and the secondary health plan will be able to request new or additional claim attachment information. We believe it will important to state so in the regulation text.</li> </ul> <p>We believe the payer-payer COB will not work, unless the provider is permitted to send ALL attachment data with the initial claim. Minimum necessary should mean that the provider is allowed to send them minimum necessary data that is needed to process the claim through the ENTIRE claim transaction cycle.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
25	55999/3	<p><b><u>4. Impact of Privacy Rule</u></b></p> <p>We generally agree with the intent of the proposed rules to make compliance with privacy regulations, in particular the "minimum necessary" provisions, easy and achievable. In situations where a health care provider is using an electronic health record (EHR) that stores information at an elemental level, the proposed rule may facilitate compliance with the minimum necessary provisions of the privacy standards. However, we believe the wording and expectations being stated in the proposed regulations will not facilitate compliance with the minimum necessary provisions of the privacy standards. Most providers, particularly smaller and medium-sized providers will not be submitting attachment information directly from an EHR, but rather from paper and electronic documents. The need to selectively edit the scanned documents will be burdensome and costly. Consequently, there will be a strong incentive to submit entire scanned documents, which would be contrary to complying with the privacy standards. This situation is particularly true if the documents already exist in a scanned format for another purpose and are not being scanned specifically for the claim attachment.</p> <p>We are very concerned with the description provided in the preamble that health care providers who choose to submit attachment information in the form of scanned documents will need to make efforts to ensure that those documents do not contain more than the minimum necessary information. This could mean that providers will need to selectively white-out certain sections of a record, document or other electronic format information. We believe this will be unreasonable and against the spirit of administrative simplification.</p> <p>Thus, we strongly recommend that the Office for Civil Rights developed a detailed guidance document on the applicability of the Privacy Rule to the submission of claim attachment information, with illustrative examples based on real-case analysis. Guidance should include a description of how patient rights (including access and restriction) and cover entity responsibilities (including minimum necessary) will impact claim attachment information for the submitter and the recipient.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
26	60000/1	<b><u>5. Impact of the Security Rule</u></b>  We believe current HIPAA Security standards cover sufficiently the submission of electronic claim attachments. But, given the significance, type, and size of information being included in claim attachments, we recommend that the OEES consider developing a guidance document on the use of security measures to protect the transmission of claim attachment information.	
27	60000/2	<b><u>6. Connection to Signatures (Hard Copy and Electronic)</u></b>  We believe that the recommended approach is sufficient and will fulfill the needs for handling signature requirements for the six proposed attachments types.  We believe that there will be a need to handle signatures differently in other future attachments, such as consent, and recommend that a plan be developed to evaluate alternative options for the adoption of electronic signature standards for the health care industry.	
28	60000/3	<b><u>7. Connection to Consolidated Health Informatics Initiative</u></b>  No comment.	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
29	60001/1	<p><b><u>8. Health Care Provider vs. Health Plan Perspective</u></b></p> <p>Issue No. 1 – How the rule applies to health plans:</p> <p>We understand that the rule applies as follows:</p> <ul style="list-style-type: none"> <li>For <b>providers</b>, if they choose to <b>submit</b> a claim attachment electronically, they have to use the standard; if they choose to <b>receive</b> a request for claim attachments electronically, they must ONLY use the electronic standard request transaction.</li> <li>For <b>health plans</b>, if they choose to <b>submit</b> a claim attachment request to a provider electronically (and the provider has chosen to receive it electronically), they must use the standard; Also, if a provider asks that the transaction be sent electronically, the payer must comply (using the standard).</li> <li>But, there seems to be a question as to the applicability of the rule to health plans, when <b>receiving</b> claim attachments from providers or other submitters: <ul style="list-style-type: none"> <li>Do they have a choice to reject a claim attachment submitted electronically by a provider (or other submitter) – if the standard is used?</li> <li>Or MUST they be READY TO RECEIVE the electronic claim attachment standards, if a provider chooses to send it electronically?</li> </ul> </li> <li>An important additional question is, if the health plan is required to be ready to accept, must the health plan be ready to accept ALL six claim attachment types (if they are adopted)? Which ones are health plans required to be ready to accept? What if the payer doesn't send the request electronically?</li> <li>We strongly recommend that clarification be made on these points, and that the proposed regulation text be modified, as appropriate.</li> </ul>	<p><b>"§ 162.1905 Requirements for covered entities.</b></p> <p>When using electronic media to conduct a health care claims attachment request transaction or a health care claims attachment response transaction, a covered entity must comply with the applicable standards of this subpart if:</p> <p>(a) Information not contained in a health care claim is needed for the adjudication of that health care claim; and</p> <p>(b) The health care claim is for one or more of the following types of services..."</p> <p>Recommendation: changes must be made to clarify the difference on how the rule applies to covered health care providers, health plans and clearinghouses</p>

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
30	60001/1	<p><b><u>8. Health Care Provider vs. Health Plan Perspective (cont.)</u></b></p> <p>Issue No. 2 - Definition of 'Advance Instructions' for Unsolicited Claim Attachments:</p> <p>We request clarification on the meaning of the word 'instructions' for purposes of establishing the parameters under which unsolicited claim attachments are to be conducted. Would it mean a separate business/legal agreement between trading partners? Could it be instructions in a billing manual? An RA Notice? A Payer Memorandum? The preamble uses different terms at different points to refer to this 'advance instructions' for unsolicited claims.</p> <p>We reiterate our strong support for the use of unsolicited claims, and request that CMS encourage more strongly its adoption and use in the final rule. This is by far the most common way of submitting the bulk of attachments today, and the way the industry will benefit the most and organizations get the best ROIs. We also request that CMS highlights the importance of collaborative activities in a regional setting, where communication and consensus between providers and payers need to exist about which transactions to do, how to do them, etc.</p>	<p>162.1920 - establishes requirement about 'only upon advance instructions'</p> <p>There is also an issue with the various words used to note the need use of word</p>
31	60001/2	<p><b><u>9. Health Care Clearinghouse Perspective</u></b></p> <p>No comment.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
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**SECTION II-E - ELECTRONIC HEALTH CARE CLAIMS ATTACHMENT CONTENT AND STRUCTURE**

32	60001/2	We strongly support the work done by the standards development organizations involved in the development of the standards for claim attachments. We do express concerns with the fact that the standards have been under development for several years, reflecting perhaps business processes that have significantly changed, particularly since the adoption of the electronic claim standards.	
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**SECTION II-F - ALTERNATIVES CONSIDERED: CANDIDATE STANDARDS FOR TRANSACTION TYPES AND CODE SETS**

33	60002/1	We believe that the process used to identify and evaluate alternative candidates for standards for transaction types and code sets was thorough and comprehensive.	
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**SECTION II-G - PROPOSED STANDARDS**

34	60004/2	<b><u>1. Code Sets</u></b>  We understand the LOINC code set is being considered as an external medical code set. We have concerns about the lack of a defined timeline for when changes/updates to the code set will be in effect for the industry (as it is the case for all other external code sets).  For those booklets that do not limit the LOINC codes to those listed on the AIS, when would a change/addition of a code be effective? There needs to be a defined schedule for when new/change codes will be effective. We strongly recommend that the code set maintainer be required to establish such timelines (once every quarter or twice a year, for example).	
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Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
35	60005/1	<p><b><u>2. Electronic Health Care Claims Attachment Request Transaction</u></b></p> <p>Issue No. 1 – CDA Version to be adopted</p> <ul style="list-style-type: none"><li>■ As noted earlier, we recommend the adoption of Version 2.0 of the Clinical Document Architecture.</li></ul> <p>Issue No 2 – Difference in Way AIS Documents Reference LOINC Codes</p> <ul style="list-style-type: none"><li>■ We are also concern about the fact that three of the proposed claim attachment types (Rehabilitation, Emergency Department and Ambulance Service) incorporate into the standard specification (the AIS document) the detailed LOINC codes required to be reported, while the other three claim attachment types don't.</li><li>■ We believe this creates a dual standard for handling changes/updates to the standards (and a different regulatory process to go through, depending on which claim attachment type standard is being modified). For example, we believe that with these three AIS documents there would be a requirement to go through the rulemaking process in order to expand or modify the LOINC codes being used inside those booklets, whereas for the other three AIS documents, it seems additions/changes to the LOINC codes referenced will be possible to be done without going through the rulemaking process.</li></ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
36	60005/1	<p><b><u>2. Electronic Health Care Claims Attachment Request Transaction (cont.)</u></b></p> <p>Issue No. 3 – Relevance of Certain Claim Attachment Types and LOINC Codes to Current Business Practices</p> <ul style="list-style-type: none"> <li>■ As mentioned earlier, we have significant concerns with the relevance of certain claim attachment types and LOINC codes in light of the significant changes that the health care industry has been going through over the past 4 years.</li> <li>■ For example, we have found out that in our particular region, NONE of the payers or providers request/submit emergency department reports. This seems to be somewhat of an astonishing fact, in light of the intent of the proposed rules to adopt this as one of the claim attachment standards.</li> <li>■ We are very concerned with the lack of basic, quantifiable information on the level of use, relative volume and type of priority requirements that exist currently in the market, as it relates to claim attachments types.</li> </ul> <p>Issue No. 4 – Adoption and then Requirement to Implement the Six Standards at Once</p> <ul style="list-style-type: none"> <li>■ We believe that requiring these six standards to be implemented all at once creates significant burdens on health plans, clearinghouses and even larger providers who conduct businesses in those areas affected by the adopted claim attachment types.</li> </ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
37	60005/1	<p><b><u>2. Electronic Health Care Claims Attachment Request Transaction (cont.)</u></b></p> <p>Issue No. 5 - Inconsistencies with how the Preamble, the Rule and the AIS documents References LOINC Codes:</p> <ul style="list-style-type: none"> <li>■ Description of the AIS Laboratory Results Attachment mentions "The instructions and <i>partial</i> list of LOINC codes..." whereas all the other AIS descriptions mention "The instructions and list of LOINC codes..."</li> <li>■ The standards identified reference the LOINC codes that must be those specified in the AIS - does this also include the ones referenced as being listed outside on the actual AIS booklets ("what is listed here is not the full one...")</li> </ul>	
38	60005/3	<p><b><u>3. Electronic Health Care Claims Attachment Response Transaction</u></b></p> <ul style="list-style-type: none"> <li>■ We strongly recommend that the electronic submission of unsolicited claim attachments (for one of the six proposed types) be required to follow the adopted standard. As noted before, we believe this point is not sufficiently clear.</li> <li>■ The standards identified reference the LOINC codes that must be those specified in the AIS - does this also include the ones referenced as being listed outside on the actual AIS booklets ("what is listed here is not the full one...").</li> <li>■ We believe there is very little quantifiable documentation on the types and volumes of various claim attachment types currently being used in the industry. We recommend CMS conduct a large scale industry survey on this topic.</li> </ul>	
39	60006/2	<p><b><u>4. Examples of How Electronic Health Care Claims Attachments Could Be Implemented</u></b></p> <p>No comment.</p>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
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**SECTION II-H - REQUIREMENTS (HEALTH PLANS, COVERED HEALTH CARE PROVIDERS AND HEALTH CARE CLEARINGHOUSES)**

40	60012/1	<p><b>General</b></p> <p>Issue No. 1 - Applicability of Regulations to Health Plans and Providers:</p> <ul style="list-style-type: none"> <li>■ Please see above, Comment on Section II-D (8) - Page 60001/1.</li> </ul> <p>Issue No. 2 - Applicability of Regulations to Various Types of Electronic Media/Methods</p> <ul style="list-style-type: none"> <li>■ How would the regulations apply in situations where data is being provided via web systems (whether providers submitting data into health plan web applications or health plans obtaining data from provider web applications).</li> <li>■ How would the regulations apply when no data is transferred or exchanged, but accessed via web applications?</li> <li>■ We recommend clarification and specific regulatory language on how to address this issue.</li> </ul> <p>Issue No. 3 - Ability of health plans to request additional information via other means to verify the information reported in the attached documentation</p> <ul style="list-style-type: none"> <li>■ We are concerned that the language used in the preamble creates a risk for maintaining unpaid claims while non-electronic requests for additional information are sent back and forth between payers and providers.</li> <li>■ We strongly recommend that the final rule specify more clearly the intent for allowing payers to use other processes to verify information reported in an attachment without unfairly delaying the processing and payment of a claim.</li> </ul>	
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Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
41	60012/1	<p><b>General (cont.)</b></p> <p>Issue No. 4 - Use of Electronic and Non-Electronic Methods Within Attachment Types</p> <ul style="list-style-type: none"> <li>■ We request clarification on whether covered providers and payers will be able to choose <u>FROM WITHIN</u> a claim attachment standard type to submit/receive <u>ONLY certain parts</u> electronically and other parts via non-electronic methods.</li> <li>■ Or, whether they could send different attachment type applications for the same attachment type via different methods (i.e., the Clinical Reports, some of the applications send via paper and some electronically).</li> <li>■ We recommend that the standards offer as much flexibility as possible on this issue, so that it doesn't become an 'all or nothing' decision to submit claim attachments electronically. Trading partners will like to have the ability to submit as much information as possible via electronic means, even if they still have to submit some information via non-electronic means.</li> <li>■ This point emphasizes the need for collaboration between providers, payers and clearinghouses to coordinate the submission/receipt of electronic + paper attachments (payers needing to link a piece of information coming electronically with another piece of information coming on paper).</li> </ul>	
42	60012/1	<p><b>General (cont.)</b></p> <p>Issue No. 5 - Maximum Data Set</p> <ul style="list-style-type: none"> <li>■ Limiting to only those LOINC codes, it will prohibit covered entities from request and sending LOINC codes not defined and included in the AIS standard.</li> <li>■ We reiterate our concern about standard versioning and maintenance and how cumbersome the process is to change adopted standards, when there might be a need to respond quickly to changes in the industry (i.e., new technologies).</li> </ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
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**SECTION II-I - SPECIFIC DOCUMENTS AND SOURCES**

43	60013/1	No comment.	
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**SECTION III - MODIFICATIONS TO STANDARDS AND NEW ELECTRONIC ATTACHMENTS**

**SECTION III-A - MODIFICATIONS TO STANDARDS AND**

**SECTION III-B - ADDITIONAL INFORMATION SPECIFICATIONS FOR NEW ELECTRONIC ATTACHMENTS**

44	56013/3	We reiterate our comments made earlier about the issues associated with the need to use an NPRM process to modify the standards (including adding new LOINC codes to an existing type). We support the recommendations from the WEDI PAG with respect to adopting a more streamlined and efficient process for adopting changes to the standards.	
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Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
45	60014/1	<p>Comment on A) and B) Modifications and New Standards</p> <p>Issue 1 - Process is too slow as described (HL7 to DSMO to NCVHS to HHS)</p> <ul style="list-style-type: none"> <li>■ Would process be faster if the changes are smaller?</li> <li>■ Is CMS limited by the overall HIPAA Law in terms of how often modifications can be adopted and how quickly they are expected to be complied with (once a year, 180 days compliance)?</li> <li>■ We would very much support an alternative process that speeds up the process of adopting modifications to the standards.</li> <li>■ We believe the challenge of any alternative process (or even the current process) will be industry communications, proactive involvement and participation.</li> </ul> <p>Issue 2 - X12 Standards included</p> <ul style="list-style-type: none"> <li>■ Same speeded-up regulatory process recommendation should applied to X12</li> </ul> <p>Issue 3 - Need to coordinate new claim attachment types with the impact on the actual claim transaction</p> <ul style="list-style-type: none"> <li>■ There should be consistent parameters and a standard methodology to evaluate the data that will be proposed to be made part of a new claim attachment standard vis-à-vis the incorporation of that data in the claim transaction.</li> </ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
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**SECTION III-C - USE OF PROPOSED AND NEW ELECTRONIC ATTACHMENT TYPES BEFORE FORMAL APPROVAL AND ADOPTION**

46	60014/2	While we strongly support the concept that the industry can begin using the proposed standards before the formal approval and adoption, we are concerned that vendors, clearinghouses, plans and providers will not be willing to invest time and resources needed to implement the many system and business process changes required to implement these proposed standards.	
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**SECTION VI - REGULATORY IMPACT ANALYSIS**

**SECTION VI-A - OVERALL IMPACT AND**  
**SECTION VI-B - COST AND BENEFIT ANALYSIS**

47	60014/3	<p>Issue No. 1 - Claim Volume data</p> <ul style="list-style-type: none"><li>■ Based on 2000 Gardner assessment, inflated annually by a percentage using Medicare claim volume experience.</li><li>■ Generally agree with the numbers projected through this method.</li></ul> <p>Issue No. 2 - Claim Attachments volume data is based on the 1993 WEDI report</p> <ul style="list-style-type: none"><li>■ Business processes, system applications and data privacy in 1993 were very different. We are concerned that the numbers presented are not consistent with current trends, and generally estimate a much higher level of use than what currently exists.</li><li>■ We believe there is a strong need to collect new, more accurate and reliable data on utilization of claim attachments by type.</li></ul>	
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Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
		<p>Issue No. 3 - Estimate that 25% of all claims (non-pharmacy) need an attachment</p> <ul style="list-style-type: none"> <li>■ Based on preliminary (anecdotal) data from payers, this number seems significantly higher than current experience.</li> <li>■ Most payers and providers describe claim attachments volumes ranging from 5% to 10% of all non-pharmacy claims.</li> </ul> <p>Issue No. 4 - Of the estimated 25% of all non-pharmacy claims that need an attachment, 50% are covered by the six proposed standard types</p> <ul style="list-style-type: none"> <li>■ We believe this is also inconsistent with current practice patterns. There seem to be other types of attachments with much higher volumes.</li> </ul> <p><u>Comment from Minnesota Survey Results:</u></p> <ul style="list-style-type: none"> <li>■ It is clear that the volume of claim attachments is much lower than that reported in the NPRM.</li> <li>■ In Minnesota, overall, less than 5% of the claims require a claim attachment.</li> <li>■ While the vast majority relate to Clinical Reports (over 60% of all claim attachments), the other types are spread widely and somewhat evenly, making it difficult to prioritize. For example, in the Minnesota market there aren't claim attachments being required for emergency department claims, rehabilitation claims (all attachments are submitted as prior authorizations, rather than an attachment to a claim after the service is rendered), of medication claims. At the same time, there are significant numbers of claim attachments related to DME, Home Health, EOB, COB and Consent.</li> </ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
		<p>Issue No. 5 - Savings estimates presented</p> <ul style="list-style-type: none"><li>■ Because the volume numbers (the base) seem to be much higher than actual experience, the saving estimates appear to also be much higher than expected.</li><li>■ We also challenge the assumption used in estimating the savings (that the savings of going from paper to electronic transactions on the claim side will be comparable to the savings of going from paper claim attachments to electronic claim attachments).</li><li>■ We also question whether the savings from the adoption of the original electronic transactions standards 5 years ago will actually materialize to the level originally expected and now being used as a reference for this cost-benefit analysis.</li><li>■ Finally, we think that the estimates presented don't take into account the automated processes that health plans have put in place already to take a claim+attachment today and dump it and archive them as a scanned document, which might need to be retrofitted or reengineered to adapt to the proposed standard.</li></ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
		<p>Issue No. 6 - Assumption of a successful adoption and transition within two years</p> <ul style="list-style-type: none"> <li>■ The cost benefit analysis predicts that the industry will successfully implement the proposed electronic claim attachment standards. The analysis uses the current Medicare experience with adoption of claims electronically (reported at a 99% level). The analysis doesn't seem to take into account the fact that Congress passed a Law (ASCA) that MANDATED the submission of electronic claims to Medicare.</li> <li>■ We would also like to see projections of adoption of claim attachments based not just on the adoption of claims (837s) but also the adoption of other transactions (claim payment, eligibility, referral, etc).</li> <li>■ Furthermore, the assumption that 20% of attachments will be implemented even prior to the compliance date (assuming a compliance date of Sept 2008) seems to be even less realistic, given that the industry is currently preparing for other priorities (NPI, Medicare Part D), there is uncertainty of which types of attachments will actually be adopted, etc.</li> <li>■ Finally, we believe that the statement "Even if our assumption is incorrect, and the costs of implementing the electronic health care claims attachments standards exceed the UMRA threshold, we believe that anticipated benefits of the proposed rule justify the added costs." (56015 - Col 3) should be supported with additional explanation about the actual benefits that justify the added costs.</li> </ul>	

Comment #	Page/Column	Summary of Issue and Comment	Notes Regarding Modification to Proposed Rule Language
		<p><b>IN SUMMARY:</b></p> <ul style="list-style-type: none"><li>■ Real, actual volumes TODAY of various attachment types need to be collected<ul style="list-style-type: none"><li>○ On each type of attachments, how they are done, etc.</li></ul></li><li>■ Pilots on all attachment types need to be documented.</li><li>■ More current/accurate cost-benefit analysis data needs to be collected<ul style="list-style-type: none"><li>○ On each attachment type.</li></ul></li><li>■ Real ROI needs to be documented.</li><li>■ Realistic expectations need to be established about the ability for the industry to transition on all six during a two-year period after the adoption of the rule.</li><li>■ What are the real benefits/costs about pulling out data from claims and now putting it into an attachment.</li></ul>	



## 2005 Minnesota Claim Attachment Survey Project



### Summary Report of Survey Results

January 19, 2006



### *Overview of Claim Attachment Survey*

## Purpose of the Survey

- The purpose of the Minnesota Claim Attachment Survey was two-fold:
  - Provide a baseline for Minnesota health care industry on the current claim attachment practices, the frequency of use by priority types, the general guidelines for need of attachments, etc.
  - Support with quantifiable information specific comments that will be submitted to CMS related to the recently published Notice of Proposed Rule Making (NPRM) on the adoption of Electronic Standards for Health Care Claim Attachments

## Survey Focus

- Claim Attachment Types Proposed on NPRM:
  - Clinical reports (including anesthesia, arthroscopy, cardiac catheterization, colonoscopy, consultation notes, cytology reports, etc)
  - Laboratory results
  - Medication information
  - Rehabilitation consults (including substance abuse, cardiac rehab, medical social services, occupational therapy, physical therapy, speech therapy, respiratory therapy, psychiatric rehab and skilled nursing rehab)
  - Emergency department reports
  - Ambulance service reports

## Survey Focus

- **Additional Claim Attachment Types (not proposed on NPRM):**
  - Durable Medical Equipment (DME)
  - Home Health Services
  - Periodontal Services
  - Children's Preventive Health Services
  - Consent information (such as needed for sterilization or hysterectomies)
  - Other

## Survey Participants

- **Minnesota health care organizations invited to participate in the survey included the following entities:**
  - Major health care systems, including: Allina Hospitals and Clinics; Mayo Clinic; Fairview Health System; Park Nicollet Health Services; HealthEast; Hennepin County Medical Center; and St. Mary's/Duluth Clinic
  - Major health plans, including: Medicare Part A and Part B; Medicaid; Blue Cross and Blue Shield of Minnesota; HealthPartners; Medica; PreferredOne; UCare; and Metropolitan Health Plan

## Survey Participants

### ■ Responses were received from the following organizations:

- Allina
- HealthEast
- Mayo
- Park Nicollet
- Blue Cross/Blue Shield of MN
- MN Medicaid (DHS)
- HealthPartners
- Medica
- UCare

## Survey Methodology

### ■ Survey Instruments

- A separate set of survey instruments were developed for Providers and Plans
- Each set of instruments included the following sections (based on the various claim attachment types):
  - Overall Introductory Questionnaire (Section A)
  - Ambulance Claims Attachments Questionnaire (Section B)
  - Emergency Department Claim Attachments Questionnaire (Section C)
  - Rehabilitation Services Claim Attachments Questionnaire (Section D)
  - Clinical Reports Claim Attachments Questionnaire (Section E)
  - Laboratory Claim Attachments Questionnaire (Section F)
  - Medications Claim Attachments Questionnaire (Section G)
  - Other Claim Attachments Questionnaire (Section H)

## Survey Methodology

### ■ Survey Data Collection

- Survey instruments were submitted electronically to an identified contact person from each of the provider and health plan organizations invited to participate
- Survey instruments were drafted in a way that the identified contact in each organization was able to distributed separate questionnaire to appropriate staff with knowledge on the specifics of the corresponding claim attachment type
- Data collection took place between December 15, 2005 and January 10, 2006.

## Data Analysis and Reporting

- Survey results presented separately for Plans and Providers
  - Overall finding (all claim attachment types)
  - Specific finding by claim attachment type
- Findings to be incorporated into the Minnesota NPRM Comment Document
- Report to be submitted as an attachment to the Minnesota Comments



## *Summary of Survey Results*

### Overall Findings – Health Plans

- Total non-pharmacy claims reported by survey respondents in 2004 were 77 million (represents a very large proportion of the total claims in Minnesota, estimated at 100 million)
  - Institutional: 8 million
  - Professional: 64 million
  - Dental: 1 million
  - DME and other: 4 million
- Estimated pharmacy claims were 51 million in 2004

*NOTE: Breakout numbers by type of claim are less reliable, since only a few payers were able to report them*

## Overall Findings – Health Plans

- Which of the proposed six claim attachment standards should be adopted now?

Claim Attachment Type	Yes	No
Ambulance	2	3
Emergency Department	0	5
Rehabilitation/Therapy	0	5
Clinical Reports	2	3
Laboratory Results	0	5
Medications	1	4

## Overall Findings – Providers

- Which of the proposed six claim attachment standards should be adopted now?

Claim Attachment Type	Yes	No
Ambulance	0	4
Emergency Department	1	3
Rehabilitation/Therapy	1	3
Clinical Reports	3	1
Laboratory Results	2	2
Medications	1	3

## Overall Findings – Health Plans

- Rank the order in which you believe they should be implemented (1=highest priority)

Claim Attachment Type	Rank
Ambulance	1
Emergency Department	N/A
Rehabilitation/Therapy	N/A
Clinical Reports	2
Laboratory Results	N/A
Medications	3

## Overall Findings – Providers

- Rank the order in which you believe they should be implemented (1=highest priority)

Claim Attachment Type	Rank
Ambulance	N/A
Emergency Department	5
Rehabilitation/Therapy	2
Clinical Reports	1
Laboratory Results	3
Medications	4

## Overall Findings – Health Plans

- Rank the following other claim attachment types, not currently being considered for adoption of national standards (1=highest priority)

Claim Attachment Type	Rank
Durable Medical Equipment	1
Home Health Services	2
Periodontal Services	5
Consent	6
Secondary Payer Questionnaire	3
Children's Preventive Health Services	4

## Overall Findings – Providers

- Rank the following other claim attachment types, not currently being considered for adoption of national standards (1=highest priority)

Claim Attachment Type	Rank
Durable Medical Equipment	1
Home Health Services	2
Periodontal Services	5
Consent	4
Secondary Payer Questionnaire	6
Children's Preventive Health Services	3

## Overall Findings – Plans (✓) and Providers (✕)

■ Rank the following other common claim attachment types

TYPE	<u>High</u> (very frequently used)	<u>Medium</u> (somewhat frequently used)	<u>Low</u> (rarely used)
EOB/EOP/EOMB	✓ ✕		
Itemized Bill	✓ ✕		
Certificate/Letter Of Medical Necessity	✕	✓	
Copy Of Insurance Card			✓ ✕
Authorization		✕	✓
COB Information	✓ ✕		

## Overall Findings – Plans (✓) and Providers (✕)

■ Rank the following other common claim attachment types

TYPE	<u>High</u> (very frequently used)	<u>Medium</u> (somewhat frequently used)	<u>Low</u> (rarely used)
Referral		✕	✓
Accident Information (No Fault, Workers' Comp)	✕		✓
Admit/Discharge Summary		✕	✓
Payor Specific Claim Form			✓ ✕
State/Federal Mandated Forms For Medicaid/Medicare	✓	✕	
Plan Of Treatment		✕	✓

## Overall Findings – Plans (✓) and Providers (✕)

Rank the following other common claim attachment types

TYPE	<u>High</u> (very frequently used)	<u>Medium</u> (somewhat frequently used)	<u>Low</u> (rarely used)
Accident Report	✕		✓
Affidavits Of Non Coverage			✓ ✕
Appeals Forms	✕		✓
Assignment Of Benefit			✓ ✕
Audit Information			✓ ✕
Concurrent Care			✓ ✕

## Overall Findings – Plans (✓) and Providers (✕)

Rank the following other common claim attachment types

TYPE	<u>High</u> (very frequently used)	<u>Medium</u> (somewhat frequently used)	<u>Low</u> (rarely used)
High Cost Pass Through Invoices		✕	✓
Insurance Disclaimer Letter			✓ ✕
Office Records	✕		✓
Postpartum Mom/Baby Visits			✓ ✕
Pre-Existing Info		✓ ✕	
Proof Of Timely Filing		✓ ✕	

## Overall Findings – Plans (✓) and Providers (✕)

■ Rank the following other common claim attachment types

TYPE	High (very frequently used)	Medium (somewhat frequently used)	Low (rarely used)
Re-Pricing Sheets			✓ ✕
Revenue Codes		✓ ✕	
Signatures			✓ ✕
Special Forms, E.G. Rape Victims Exam Form			✓ ✕
Split Bill			✓ ✕
Test Descriptions		✕	✓

## Overall Findings – Plans (✓) and Providers (✕)

■ Rank the following other common claim attachment types

TYPE	High (very frequently used)	Medium (somewhat frequently used)	Low (rarely used)
UPIN		✕	✓
Utilization Review			✓ ✕
Waivers		✕	✓
X-Rays			✓ ✕



## *Summary of Survey Results*

*~ Health Plans ~*

### *Ambulance Claim Attachment Section*

## Survey Findings - Ambulance Claim Attachment

- Of all ambulance claims, payers only require an attachment in less than 2% of claims
  - Except for one payer that reported requiring attachments on 25% of the ambulance claims
- Most common reasons for requiring ambulance claim attachments
  - Medical policy
  - Only need ambulance attachment for air transports
  - Need zip code on Medicare claims to determine pricing

## Survey Findings - Ambulance Claim Attachment

- Most common types of ambulance attachment information currently requested
  - Ambulance report
  - Zip codes
- In what methods or forms do you most often receive ambulance claim attachments?
  - All payers reported receiving information via paper (mailed or faxed) and one also reported receiving scanned materials via email
  - None reported receiving electronic transactions (HL7)

## Survey Findings - Ambulance Claim Attachment

- In what form is ambulance attachment information kept in organization?
  - All payers consistently reported maintaining information in a scanned image format
  - None reported maintaining paper form, computer document (such as Word®) or report printed by an application
- Of all ambulance claim attachments submitted by providers, what percentage where:
  - Included with the original claim (unsolicited) ..... 90-100%
  - Submitted after payer requested the attachment ..... 0-10%

## Survey Findings - Ambulance Claim Attachment

- For unsolicited ambulance attachments, all payers reported providing written guidelines/instructions to submitters about the type of claim attachment information needed to be submit in an unsolicited manner
- One payer reported the following specific expectation: A Trip Ticket with All Air Ambulance Claims

## Survey Findings - Ambulance Claim Attachment

- Is this dataset sufficient to fulfill all current business requirements for ambulance claim attachments?
  - 1   YES      4   NO
- If No, other information needed:
  - Signature of "physician" documenting need for hospital to hospital or LTC to LTC transfers
  - Detailed information for foreign air ambulance claims
  - Ability to ask for narrative for unlisted codes

## Survey Findings - Ambulance Claim Attachment

- How long do you anticipate it will take your organization to implement the standard as proposed
  - All payers reported greater than 19-24 months
- How much do you anticipate it will cost your organization to implement the proposed
  - One payer reported between \$0.5-1.0 million
  - One payer reported > \$1.0 million
  - Other payers don't know

## Survey Findings - Ambulance Claim Attachment

- Medicare did a study recently and determined that they did not require attachments for ambulance services. The data they need is in the claims. Based on your organization's current ambulance claim attachment experience, do you believe the proposed claim attachment standard is needed?
  - 2   YES      3   NO
- If no, why:
  - Required information already on the claim
  - As long as providers submit additional information to process air ambulance claims



## *Summary of Survey Results*

*~ Health Plans ~*

*Emergency Department  
Claim Attachment Section*

## Survey Findings – Emergency Department Claim Attachment

- Of all emergency department claims, payers reported that they DO NOT require an attachment AT ALL
- In the past, attachments were required, but payers reported that they stop requiring them because:
  - Change in business practice
  - Information is now included in the claim

## Survey Findings – Emergency Department Claim Attachment

- One of the main reason for ever requiring an attachment in an emergency department claim was to indicate if the patient went twice in a day to the emergency department, to avoid possible denial for duplicate
- The most common type of information requested include:
  - Emergency visit clinic reports
  - Lab results
  - Diagnostic tests

## Survey Findings – Emergency Department Claim Attachment

- In what methods or forms do you most often receive emergency department claim attachments?
  - All payers reported receiving information via paper (mailed or faxed) and one also reported receiving scanned materials via email
  - None reported receiving electronic transactions (HL7)

## Survey Findings – Emergency Department Claim Attachment

- In what form is emergency department attachment information kept in organization?
  - All payers consistently reported maintaining information in a scanned image format
  - None reported maintaining paper form, computer document (such as Word®) or report printed by an application
- Of all emergency department claim attachments submitted by providers, what percentage where:
  - Included with the original claim (unsolicited) ..... 100%
  - Submitted after payer requested the attachment ..... 0%

## Survey Findings – Emergency Department Claim Attachment

- For unsolicited emergency department attachments, all payers (except one) reported providing written guidelines/ instructions to submitters about the type of claim attachment information needed to be submit in an unsolicited manner

## Survey Findings – Emergency Department Claim Attachment

- Is this dataset sufficient to fulfill all current business Requirements for Emergency Department claim attachments?

■ ☒ 5 YES    ☐ 0 NO

- If No, other information needed:

■ N/A

## Survey Findings – Emergency Department Claim Attachment

- How long do you anticipate it will take your organization to implement the standard as proposed

■ All payers reported greater than 19-24 months

- How much do you anticipate it will cost your organization to implement the proposed

■ One payer reported between \$0.5-1.0 million

■ One payer reported > \$1.0 million

■ Other payers don't know

## Survey Findings – Emergency Department Claim Attachment

- Medicare did a study recently and determined that they did not require attachments for emergency department services. The data they need is in the claims. Based on your organization's current emergency department claim attachment experience, do you believe the proposed claim attachment standard is needed?

☐ \_\_0\_\_ YES    ☐ \_\_5\_\_ NO

- If no, why:

- Outdated information - most data elements not required
- Rarely need additional information that is not already contained on the claim form



### *Summary of Survey Results*

*~ Health Plans ~*

*Rehabilitation Services*  
*Claim Attachment Section*

## Survey Findings – Rehab. Claim Attachment

- Of the total number of rehab. claims processed by payers in 2004 (approx. 4 million)
  - 20% were physical therapy claims
  - 15% were occupational therapy claims
  - 5% were speech therapy claims
  - 60% were other therapy claims (including respiratory, psychology, etc)

## Survey Findings – Rehab. Claim Attachment

- All payers reported that they do not require attachments to rehab. claims
  - Only one payer reported that approximately 5% of their rehab. claims required an attachment
- Most common reasons for requiring rehab. claim attachments (applicable to all type of rehab. claims)
  - Medical necessity

## Survey Findings – Rehab. Claim Attachment

- Most common type of rehab. attachment information currently requested
  - If a prior authorization is required payer obtains all of the information that is needed prior to the services being performed
  - Rarely does payer need to ask for additional information after the claim has been incurred
- In what methods or forms do you most often receive rehab. claim attachments?
  - All payers reported receiving information via paper (mailed or faxed) and one also reported receiving scanned materials via email
  - None reported receiving electronic transactions (HL7)

## Survey Findings – Rehab. Claim Attachment

- In what form is rehab. attachment information kept in organization?
  - All payers consistently reported maintaining information in a scanned image format
  - None reported maintaining paper form, computer document (such as Word®) or report printed by an application
- Of all rehab. claim attachments submitted by providers, what percentage where:
  - Included with the original claim (unsolicited) ..... 95-100%
  - Submitted after payer requested the attachment ..... 0-5%

## Survey Findings – Rehab. Claim Attachment

- For unsolicited rehab. attachments, all payers (except one) reported providing written guidelines/ instructions to submitters about the type of claim attachment information needed to be submit in an unsolicited manner
- Expectations noted by payers included:
  - Only as necessary to adjudicate the claim
  - That prior authorizations are received before the services are incurred

## Survey Findings – Rehab. Claim Attachment

- Is this dataset sufficient to fulfill all current business requirements for rehab. claim attachments? (applicable to all types of rehab. claims)
  - 4   YES      1   NO
- If No, other information needed:
  - The ability to specify continuity of care, transition of care and specialty needs

## Survey Findings – Rehab. Claim Attachment

- How long do you anticipate it will take your organization to implement the standard as proposed
  - All payers reported greater than 19-24 months
- How much do you anticipate it will cost your organization to implement the proposed
  - One payer reported between \$0.5-1.0 million
  - One payer reported > \$1.0 million
  - Other payers don't know

## Survey Findings – Rehab. Claim Attachment

- Based on your organization's current rehab. claim attachment experience, do you believe the proposed claim attachment standard is needed?
  - 1   YES      4   NO
- If no, why:
  - Required information already on the claim
  - Not required for claims processing but would use for authorizations



## *Summary of Survey Results*

*~ Health Plans ~*

*Clinical Reports*

*Claim Attachment Section*

## Survey Findings – Clinical Reports Claim Attachment

- Of all health care claims, payers reported that they requires a clinical report attachment in between 1% and 5% of the cases
  - This is a significantly large number, given that the approximate total number of claims reported in this category were over 30 million
- Most common reasons for requiring clinical report claim attachments
  - Medical policy
  - Federal or State mandate/reporting requirement
  - Determining pre-existing conditions
  - Prior authorizations

## Survey Findings – Clinical Reports Claim Attachment

- **Most common types of clinical report attachment information currently requested**
  - Clinical notes/Chart sections/Care provider notes
  - Diagnostic studies/Cardiology studies/Obstetrical studies
  - Ophthalmology studies/Pathology studies/Radiology studies
  - Operative reports
- **In what methods or forms do you most often receive clinical report claim attachments?**
  - All payers reported receiving information via paper (mailed or faxed) and one also reported receiving scanned materials via email
  - None reported receiving electronic transactions (EHR exchanges, HL7)

## Survey Findings – Clinical Reports Claim Attachment

- **In what form is clinical report attachment information kept in organization?**
  - All payers consistently reported maintaining information in all ways, including paper, scanned image, computer document and printed report
- **Of all clinical report claim attachments submitted by providers, what percentage where:**
  - Included with the original claim (unsolicited) ..... 80-90%
  - Submitted after payer requested the attachment ..... 10-20%

## Survey Findings – Clinical Reports Claim Attachment

- For unsolicited clinical report attachments, all payers reported providing written guidelines/instructions to submitters about the type of claim attachment information needed to be submit in an unsolicited manner
- Specific payer expectations included:
  - Only as necessary to adjudicate the claim
  - Narrative description
  - Prior Authorization done prior to service
  - For claims with 22 modifier operative reports

## Survey Findings – Clinical Reports Claim Attachment

- Is this dataset sufficient to fulfill all current business requirements for clinical reports attachments?  
☐ 1 YES    ☐ 4 NO
- If No, other information needed:
  - All LOINC codes listed should be available - Need to add:
    - Height and weight; Protocol numbers on clinical trial; Sponsor of clinical trials; Ability to ask for narrative of unlisted codes; Physician orders; Letter of Medical Necessity; Photographs (many of them are digital now and can be submitted electronically); Breakdown of charges for specialty code; Admitting H&P

## Survey Findings – Clinical Reports Claim Attachment

- How long do you anticipate it will take your organization to implement the standard as proposed
  - All payers reported greater than 19-24 months
- How much do you anticipate it will cost your organization to implement the proposed
  - One payer reported between \$0.5-1.0 million
  - One payer reported > \$1.0 million
  - Other payers don't know

## Survey Findings – Clinical Reports Claim Attachment

- Based on your organization's current clinical report claim attachment experience, do you believe the proposed claim attachment standard is needed?
  - 2   YES      3   NO
- If no, why:
  - Cost
  - Claim attachment process already defined



*Summary of Survey Results*  
*~ Health Plans ~*  
*Laboratory Claim Attachment Section*

**Survey Findings - Laboratory Claim Attachment**

- Of all laboratory claims, payers only require an attachment in less than 1% of claims
- Most common reasons for requiring laboratory claim attachments
  - Unlisted codes
  - Need for test results on chemistry tests

## Survey Findings - Laboratory Claim Attachment

- Most common types of laboratory attachment information currently requested
  - Narrative description of unlisted codes
  - Fertility tests and Toxicology/Drug tests: Mix, sometimes all results sometimes one or a few measures
- In what methods or forms do you most often receive laboratory claim attachments?
  - All payers reported receiving information via paper (mailed or faxed) and one also reported receiving scanned materials via email
  - None reported receiving electronic transactions (HL7)

## Survey Findings - Laboratory Claim Attachment

- In what form is laboratory attachment information kept in organization?
  - All payers consistently reported maintaining information in a scanned image format
  - None reported maintaining paper form, computer document (such as Word®) or report printed by an application
- Of all laboratory claim attachments submitted by providers, what percentage where:
  - Included with the original claim (unsolicited) ..... 99-100%
  - Submitted after payer requested the attachment ..... 0-1%

## Survey Findings - Laboratory Claim Attachment

- For unsolicited laboratory attachments, all payers reported providing written guidelines/instructions to submitters about the type of claim attachment information needed to be submit in an unsolicited manner
  - Payers' specific expectations included:
    - Only as required to adjudicate the claim
    - Other than narrative descriptions, no other expectations

## Survey Findings - Laboratory Claim Attachment

- Is this dataset sufficient to fulfill all current business requirements for laboratory claim attachments?
  - 5   YES      0   NO
- If No, other information needed:
  - N/A

## Survey Findings - Laboratory Claim Attachment

- How long do you anticipate it will take your organization to implement the standard as proposed
  - All payers reported greater than 19-24 months
- How much do you anticipate it will cost your organization to implement the proposed
  - One payer reported between \$0.5-1.0 million
  - One payer reported > \$1.0 million
  - Other payers don't know

## Survey Findings - Laboratory Claim Attachment

- Medicare did a study recently and determined that they did not require attachments for laboratory services. The data they need is in the claims. Based on your organization's current laboratory claim attachment experience, do you believe the proposed claim attachment standard is needed?
  - 1   YES      4   NO
- If no, why:
  - Required information already on the claims
  - Used occasionally, but not high priority



## *Summary of Survey Results*

*~ Health Plans ~*

### *Medications Claim Attachment Section*

## Survey Findings - Medications Claim Attachment

- In general, payers reported that they did not require attachments in any of the medications-related claims
  - Except for one payer that reported requiring attachments on 5% of the medication claims
- They reported that attachments used to be required, but they stopped requiring them due to:
  - Business practice changes
  - Information provided on the claim
- Most common reasons for requiring medications claim attachments
  - Need for NDC number
  - Drugs with cost over \$1,000

## Survey Findings - Medications Claim Attachment

- **Most common types of medication attachment information currently requested**
  - NDC Codes and Drug Name
  - Medications Administered/Medications over \$1,000
- **In what methods or forms do you most often receive medications claim attachments?**
  - All payers reported receiving information via paper (mailed or faxed) and one also reported receiving scanned materials via email
  - None reported receiving electronic transactions (HL7)

## Survey Findings - Medications Claim Attachment

- **In what form is medication attachment information kept in organization?**
  - All payers consistently reported maintaining information in a scanned image format
  - None reported maintaining paper form, computer document (such as Word®) or report printed by an application
- **Of all medications claim attachments submitted by providers, what percentage where:**
  - Included with the original claim (unsolicited) ..... 90%
  - Submitted after payer requested the attachment ..... 10%

## Survey Findings - Medications Claim Attachment

- For unsolicited medication attachments, all payers reported providing written guidelines/instructions to submitters about the type of claim attachment information needed to be submit in an unsolicited manner

## Survey Findings - Medications Claim Attachment

- Is this dataset sufficient to fulfill all current business requirements for medication claim attachments?
  - ☒ 5 YES    ☐ 0 NO
- If No, other information needed:
  - N/A

## Survey Findings - Medications Claim Attachment

- How long do you anticipate it will take your organization to implement the standard as proposed
  - All payers reported greater than 19-24 months
- How much do you anticipate it will cost your organization to implement the proposed
  - One payer reported between \$0.5-1.0 million
  - One payer reported > \$1.0 million
  - Other payers don't know

## Survey Findings - Medications Claim Attachment

- Based on your organization's current medication claim attachment experience, do you believe the proposed claim attachment standard is needed?
  - 1   YES      4   NO
- If no, why:
  - Not required to adjudicate a claim but could be used for authorizations
  - Not needed if NDC dosage is available
  - Required information already on the claim



*Summary of Survey Results*  
*~ Other Care Attachments ~*

**Survey Findings – Other Claim  
Attachment – DME**

- Of all claims, what percentage are DME claims
  - Between 1% and 10%
- Of all DME claims what percentage require an attachment
  - Less than 1%
- How critical is adoption of DME claim attachment standard
  - 1 Very critical (should be implemented now)
  - 3 Somewhat critical (implemented within 5 years)
  - 1 Not critical (implemented within 10 years)

## Survey Findings – Other Claim Attachment – Home Health

- Of all claims, what percentage are Home Health claims
  - Between 1% and 3%
- Of all Home Health claims what percentage require an attachment
  - Less than 1%
- How critical is adoption of Home Health claim attachment standard
  - 0 Very critical (should be implemented now)
  - 0 Somewhat critical (implemented within 5 years)
  - 4 Not critical (implemented within 10 years)

## Survey Findings – Other Claim Attachment – Periodontal Care

- Of all claims, what percentage are Periodontal Services claims
  - Between 1% and 2%
- Of all Periodontal Services claims what percentage require an attachment
  - Less than 1%
- How critical is adoption of Periodontal Services claim attachment standard
  - 0 Very critical (should be implemented now)
  - 0 Somewhat critical (implemented within 5 years)
  - 4 Not critical (implemented within 10 years)

## Survey Findings – Other Claim Attachment – Consent

- Of all claims, what percentage require that a Consent be documented
  - Less than 1% (only one payer)
- How critical is adoption of Consent documentation claim attachment standard
  - \_1\_ Very critical (should be implemented now)
  - \_0\_ Somewhat critical (implemented within 5 years)
  - \_4\_ Not critical (implemented within 10 years)

## Survey Findings – Other Claim Attachment – 2<sup>nd</sup> Payer Questionnaire

- Of all claims, what percentage involve a 2<sup>nd</sup> Payer
  - Between 2% and 20%
- Of all claims that involve a 2<sup>nd</sup> payer, what percentage require a 2<sup>nd</sup> payer questionnaire
  - Between 20% and 100%
- How critical is adoption of 2<sup>nd</sup> payer questionnaire claim attachment standard
  - \_0\_ Very critical (should be implemented now)
  - \_2\_ Somewhat critical (implemented within 5 years)
  - \_2\_ Not critical (implemented within 10 years)

## Survey Findings – Other Claim Attachment – Children Preventive Services (CPS)

- Of all claims, what percentage are CPS claims
  - Between 1% and 5%
- Of all CPS claims what percentage require an attachment
  - Less than 1%
- How critical is adoption of CPS claim attachment standard
  - \_0\_ Very critical (should be implemented now)
  - \_0\_ Somewhat critical (implemented within 5 years)
  - \_4\_ Not critical (implemented within 10 years)